HEALTHCARE MARKETS IN POST-CONFLICT SETTINGS: EXPERIENCES OF FORMAL PRIVATE-FOR-PROFIT HEALTHCARE ORGANISATIONS IN GULU DISTRICT, NORTHERN UGANDA

JUSTINE NAMAKULA

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Abstract

There is a paradox between the post-conflict setting and the healthcare market in Northern Uganda. While there is a strong missionary sector and apparent ongoing rehabilitation of the government facilities, the popularity of the formal private for-profit sector has steadily increased in Gulu municipality, northern Uganda, which has a high poverty-afflicted population. Therefore, there is need to understand why and how we can leverage the potential of the formal private for-profit providers (FPFPs) to accelerate Universal Health Coverage (UHC) goals. The study explored the experiences of the FPFPs based in Gulu municipality regarding the market in which they operated during and after the conflict. In particular, the study sought to understand the characteristics of and changes in FPFPs over time, as well as the challenges, coping strategies, opportunities, and linkages with others in the market. This was a case study using mixed methods with a quant-qual sequential approach. The methods included organisational survey, life-history interviews, key informant interviews and observation. This study utilised the New Institutional Economics (NIE) theory as an analytical lens. Data analysis was conducted using SPSS, ATLAS.ti ver. 7.0 and UCINET ver. 11.0 software.

The findings suggest that FPFPs increased in number and experienced internal changes within individual businesses across the conflict periods. Conflict provides the context in which the FPFP businesses started and operate (d) and explains their survival patterns and the emergent regulatory context. The FPFPs were faced with diverse challenges embedded in the active conflict that further complicated operational costs and regulatory mechanisms. Notably, some of the coping strategies compromise the quality of the services provided. There is a dense relational network for FPFPs in Gulu municipality, and these numerous relational links have positive implications for the broader coverage of the goal for UHC, the reduction of transaction costs as well as their continued relevance in the market. FPFPs were continuously faced with a dilemma of balancing optimization of their incomes with their altruism objectives. In the period following conflict, FPFPs attempted to implement various mechanisms to ensure that the poor could access health care. The mechanisms were enabled by the managers' *ad hoc* judgements as well as partnerships with the local government and NGOs in the area. These ranged from price exemptions and reductions to price discrimination and breaking down doses.

The study concludes by noting that FPFPs play a critical role in service provision in post-conflict northern Uganda. However, they cannot be 'exclusively' pro-poor, given that they are formed with a profit maximization objective. Some coping strategies and some mechanisms to enable the poor to access services may compromise quality. Hence, the government needs to enforce regulations to control the number of FPFPs opening business as well as quality. There is evidence of partnerships between the government and FPFPs. This needs to be continuous and expanded to include more FPFPs if UHC goals are to be achieved.

Keywords: Healthcare markets, formal private-for-profit providers, experiences, northern Uganda, post-conflict settings, Gulu, life histories, challenges, coping strategies, opportunities, pro-poor.

Declaration

I, Justine Namakula, do solemnly declare that this submission is my original work. To the best of my knowledge, no part of this work has been plagiarized from any existing research except where acknowledgement has been made in the text, and to a substantial extent, been submitted to any university or academic institution of higher learning, and accepted for the award of any academic degree.

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Abbreviations

ARC	America Refugee Committee
AHAIC	Africa Health Agenda International Conference
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-retroviral Therapy
AVSI	Association of Volunteer Services in International Service
CDC	Centre for Disease Control
DFID	Department for International Development
FCAs	Fragile and Conflict-Affected settings
FPFPs	Formal Private For-Profit Healthcare Organisations (Providers)
GIS	Mapping and Geographic Information System
HANSHEP	Harnessing Non-State Actors for Better Health for the Poor Scheme
HC	Health Centre
HIV	Human Immunodeficiency Virus
HSSP	Health Sector Strategic and Investment Plan
IDMC	Internal Displacement Monitoring Centre
IDPs	Internally Displaced Persons
IFC	International Finance Corporation
IGHD	Institute for Global Health and Development, Queen Margaret University
INGOs	International Non-Governmental Organisations
IPs	Informal Providers
IRB	Institutional Review Board
KI	Key Informant
LH	Life History

LMICs	Low- and Middle-Income Countries
MakSPH	Makerere University School of Public Health
MDGs	Millennium Development Goals
MoFPED	Ministry of Finance, Planning and Economic Development
MOH	Ministry of Health
NDP	National Development Plan
NGO	Non-Governmental Organisation
NIE	New Institutional Economics
NRC	Norwegian Refugee Council
OECD	Organisation for Economic Cooperation and Development
OOP	Out of Pocket
P	Participant -Identification
PBF	Performance-Based Financing
PFP	Private for-profit
PNFP	Private Not-for- Profit
PPP	Public-Private Partnership
PRDP	Peace, Recovery and Development Programme
QMU	Queen Margaret University
RBF	Results-Based Financing
ReBUILD	Research for Building Pro-Poor Health Systems during Recovery from Conflict
SDGs	Sustainable Development Goals
SPEED	Supporting Policy Engagement and Dialogue for the Achievement of Universal Health Coverage

UBOS	Uganda Bureau of Statistics
UCMB	Uganda Catholic Medical Bureau
UDHS	Uganda Demographic and Health Survey
UHC	Universal Health Coverage
UK	United Kingdom
UKPCDP	United Kingdom Post-Conflict Development Programme for Northern Uganda
UMMB	Uganda Muslim Medical Bureau
UN	United Nations
UNCST	Uganda National Council of Science and Technology
UNHS	Uganda National Housing Survey
UOMB	Uganda Orthodox Medical Bureau
UPMB	Uganda Protestant Medical Bureau
USAID	United States Agency for International Development
WHO	World Health Organisation

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Glossary of Terms and Phrases

A Mapping and Geographic Information System (GIS) refers to a system designed to capture, store, manipulate, analyse, manage and present spatial or geographical data. GIS applications allow users to create interactive queries, analyse spatial information and edit data in maps.

A network is a set of links and relationships that an organisation has with other organisations within the market.

A transaction is an exchange of goods and services between the buyer and the seller. The buyer exchanges the right to use the money for the right to use the good while the seller gains the right to use the money. It is worth noting that the transactions in the health market were not mainly based on monetary terms.

Age of business refers to the number of years that an FPFP has existed since its establishment.

A boda-boda is a local name, commonly used by people in Uganda, to refer to a motorcycle that is used for commercial purposes and as a quick means of transport.

Bounded rationality implies that human beings cannot make rational decisions. This is because of three limitations: limited knowledge about all possible circumstances that could affect a situation, limited cognitive ability and limited time to decide.

Demand is the ability and willingness of an individual to buy a given good at a given price, other factors being constant.

Formal private for-profit healthcare organisations are formalized registered/licensed commercial organisations and individuals delivering health-

related services with the main objective of accumulating profit (Institute for Health Sector Development, 2004; Bloom et al., 2013). The profit generated is under the jurisdiction and use of the owners or directors of these business entities. For this study, the terms 'organisations' and 'FPFPs' are used interchangeably about formal private for-profit providers.

Information asymmetry is a situation where one party in the transaction has more information than the other party.

Institutions refer, in this study, to 'rules of the game' consisting of both legal and informal social norms that govern behaviour and structure social interactions between organisations (Williamson, 1998; Douma and Schreuder, 2002; Eggertsson, 2013).

'Itwero nongo kony me yat two-jonyo ki kany bene!' is an Acholi sentence that translates as 'HIV treatment services now available here'.

Kaveera is a local name in the Luganda language for a polythene bag. However, people from the other Ugandan tribes, including the Acholi, also use the term but simply change its tone to make it sound like English.

Market relates to a set of systems, institutions, procedures and social relations infrastructures or arrangements by which buyers and sellers exchange goods and services.

Market share refers to the number of customers that the firm can attract as well as maintain. Market share results in market power.

Market structure, according to McPake and Normand (2008), refers to the number of sellers in the market and their degree of differentiation (p.149).

Negotiation of markets refers, in this study, to the survival strategies of PFPs over their life span. Examples include how they respond to the actions of others in the health market, and how they attract clients, keep old ones despite competition and position themselves to attract opportunities as well as develop solutions to challenges.

'Old FPFPs' are those FPFPs that had existed between 10 and 33 years. These had been established slightly before conflict or during conflict.

Opportunism refers to a strategy intended to further self-interest.

Organisations are groups of people and the governance arrangement they create to co-ordinate their team action against other teams that are also performing also as business organisations. All formal private for-profit providers were referred to as 'organisations' and in some cases the word is used interchangeably with 'providers.

Private sector providers refer to any organisations working in the delivery of health services or in other related sectors that are neither run nor belong to the government (MOH, 2012). These include for-profit, not-for-profit, and community-based organisations or individuals (Institute for Health Sector Development, 2004).

'Young FPFPs' refer to the FPFPs that had existed between 1 and 9 years in business. These were established after 2006.

CHAPTER 1: INTRODUCTION

This chapter sets the background for the thesis, and presents the global, national, and regional backdrop against which this study is set. The focus is on how commitments have inspired the interest in health in general, but the importance of multi-sectoral actors, including the private sector, is also highlighted. How these global agendas have been adapted to the national context is outlined. This is followed by the motivation, study rationale as well as research objectives. Lastly, an overview of the thesis is presented.

1.0. Background to the Study

In the context of global development agendas, such as Universal Health Coverage (UHC) and Sustainable Development Goals (SDGs), donors, scholars and governments have continued to recognise the centrality of health both as contributing to and as a consequence of all other 16 development goals.[1] Based on the realisation that health is not just the responsibility of the Ministry of Health and the state, the importance of multi-sectoral action in relation to the achievement of Sustainable Development Goal 3 is now being underscored (Rasanathan et al., 2017). As such, other government ministries and departments as well as other actors, including civil society and the private sector, have been called upon to support its achievement. In the last decade, there has been increased recognition that health service provision in low- and middle-income countries (LMICs) cannot be left to the government alone (Walker, 2009). The need to achieve global goals such as UHC has led countries to

[1]https://www.who.int/sustainable-development/sdg-briefs/en/

make deliberate efforts over time, among which is the effort to harness the capacity of non-state actors such as the private sector (both not-for-profit and for-profit) (WHO, 2005, 2010, 2013; UN, 2012; World Bank, 2013; Mathauer and Carrin, 2010; Sachs, 2012).

Unlike the private not-for-profit (PNFP) sector, which has for so long been engaged in the advancement of UHC goals, the role of the private-for-profit sector, as a sub-set of the private sector, has always been subject to extensive debate; such debates have increased in the context of UHC (Kamal- Yani, 2015, Montagu, 2015). There is an abundance of literature on the role of the private for-profit health sector in LMICs (Smith et al., 2001; De Costa and Diwan, 2007; Bloom et al., 2013; Lagomarsino, 2013; Lucas, 2013). Indeed, the contribution of the private sector in Uganda, particularly in relation to the treatment of child-related illnesses such as diarrhea, malaria and pneumonia (Rutebemberwa, 2009, 2011; Awor et al., 2012) as well as tuberculosis, acute respiratory infections and opportunistic diseases related to HIV/ AIDS (Konde-Lule et al., 2006; Konde-Lule et al., 2010) cannot be ignored.

In most stable LMIC settings, factors that enable the private sector to emerge include an attractive investment climate; a fair, efficient and contestable market; easy access to financial services; appropriate skills, technology and connectivity through good infrastructure and information technology (IT). I examine this further in Chapter 2.

However, with a few exceptions, including the Africa Health Agenda Conference (AHAIC, 2019) held in Kigali Rwanda from 5 to 7 March 2019, discussions about the role that the private sector plays in conflict-affected settings and its contribution to

UHC goals have been limited. Yet, the OECD report on States of Fragility predicts that ‘without action, more than 80% of the world’s poorest will be living in fragile contexts by 2030’ (OECD, 2018: 3) and that this will have great implications for the achievement of the SDG target by that year.

Documentation of contextual factors that could particularly inhibit or promote the private for-profit organisations’/sector’s capacity to contribute to such goals has been limited, including discussions on how the private for-profit sector, particularly the formal private-for-profit (FPFP), gets established and survives in post-conflict settings. Knowledge of the general experiences, challenges, opportunities, and negotiation of markets in these settings has also not well been documented. Some scholars have argued that fragile and conflict-affected states (FCAS) represent ‘frontier economies’(Addison et al., 2001)through which indigenous businesses not only contribute to UHC but also help strengthen the health system in the long run. Indeed, it has been argued that engagement of the local private sector in FCAS presents a number of benefits, as indicated by (Avis, 2016) and (De Vries and Specker, 2009). These include having a greater interest in peace-building and stabilisation efforts than in large enterprises as they suffer more from conflict, and increasingly have sub-national urban centres as their base, providing a stimulus for regional development and boosting the ability to maintain linkages with other local enterprises.

However, fragile and conflict-affected settings pose challenges, such as the absence of many of the factors listed previously (on p. 2), as well as suspicion of the private sector, limited basic services, rent-seeking and weak government with questionable legitimacy (Avis, 2016). According to a World Bank report, other challenges

encountered by the private sector in such settings include excessive business regulation, unpredictable government behaviour and high transaction costs (WorldBank, 2016).

Amidst all these challenges, the private sector has shown a capability to survive in difficult situations (WorldBank, 2005, World Bank., 2016), with Sweeney (2009) arguing that it often remains (largely) resilient to systemic shocks, as it is able to change shape and direction (see timelines presented in findings). Notably, the private sector and the health market in FCAS present a paradox as poor populations continue to seek services from these providers. In Gulu municipality, post-conflict Northern Uganda, for instance, there is a strong missionary sector, as well as ongoing rehabilitation of government facilities. Yet, despite having a high poverty-afflicted population, people seek services from the private for-profit sector (Fustukian et al., 2017). Some providers that existed prior to the conflict disappeared in the conflict, others survived, and many more were established after the conflict. Therefore, there is a need to understand the trajectory of the FPFPs in Northern Uganda, the changes they encountered, and how they survived and coped with the challenges they faced both during and after conflict. The study sought to identify opportunities for FPFPs and how they strategically positioned themselves to benefit from or take advantage of such opportunities.

It is also important to investigate the extent to which FPFPs can contribute to the promotion of an equitable and pro-poor health system in Northern Uganda during and after the conflict. Additionally, considering the acceleration of the UHC goals, it is important to explore how and when to leverage the potential of the FPFPs. The study

sought to identify some innovations employed by the FPFPs to contribute to pro-poor access (or the wider UHC goals), while still maximising their incomes.

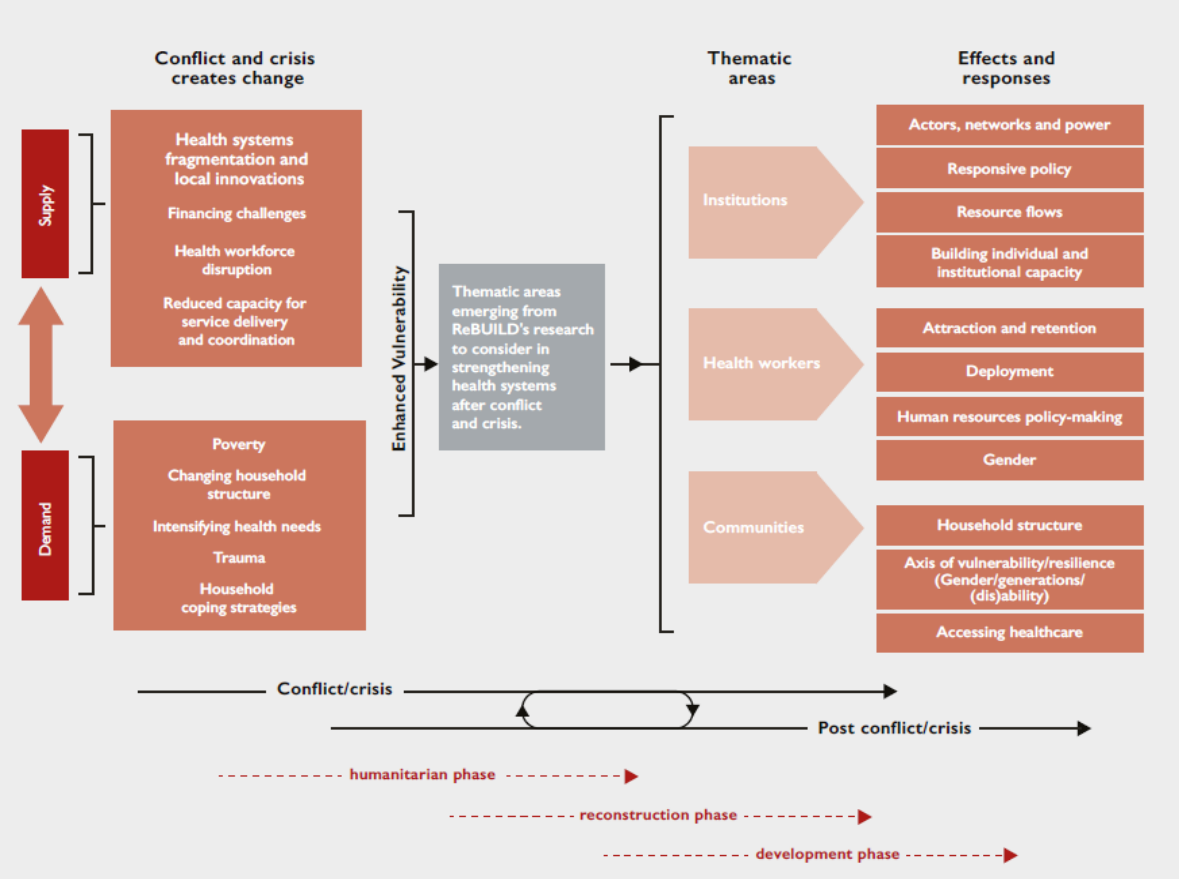
1.1. Motivation to Conduct the Study

The motivation to conduct this study was threefold and arose from a) the aspiration to contribute to the ReBUILD Consortium objective; b) fieldwork experiences as coordinator; and c) the aspiration to contribute to wider global debates.

a) The aspiration to contribute to the wider ReBUILD Consortium research (2011 to early 2019)

First, this study sought to contribute to the overall objectives of the ReBUILD Consortium research. In general, ReBUILD focused on addressing the neglected area of health systems research in fragile and conflict-affected settings (ReBUILD Consortium, 2018). The aim of the research consortium was to *'provide research evidence to guide policy and practice for improving pro-poor health systems' reconstruction in settings affected by conflict and crisis'.*[2] This objective is echoed in my study aim. The key thematic areas were institutions, communities, and human resources for health/the health workforce. Figure 1 shows the three general thematic areas for the ReBUILD Consortium and related issues affecting the strengthening of health systems after conflicts and crises.

Figure 1: Broader ReBUILD Consortium research in a snapshot



Source: ReBUILD Consortium
https://rebuildconsortium.com/media/1689/rebuild_summary.pdf

In Uganda, ReBUILD's (2011-2019) seven six sub-studies were implemented under the general programme and these included this doctoral study. Under the institution's sub-themes, two studies on aid architecture (also known as Study 5) and strategic purchasing (PBF)*[2] were conducted. The communities theme had a study on patterns of household expenditure over time (Study 1) as well as on gender, disability, and demographic scar*. The health workers theme informed the studies on human resources for health incentives (Study 2) and rural posting (Study

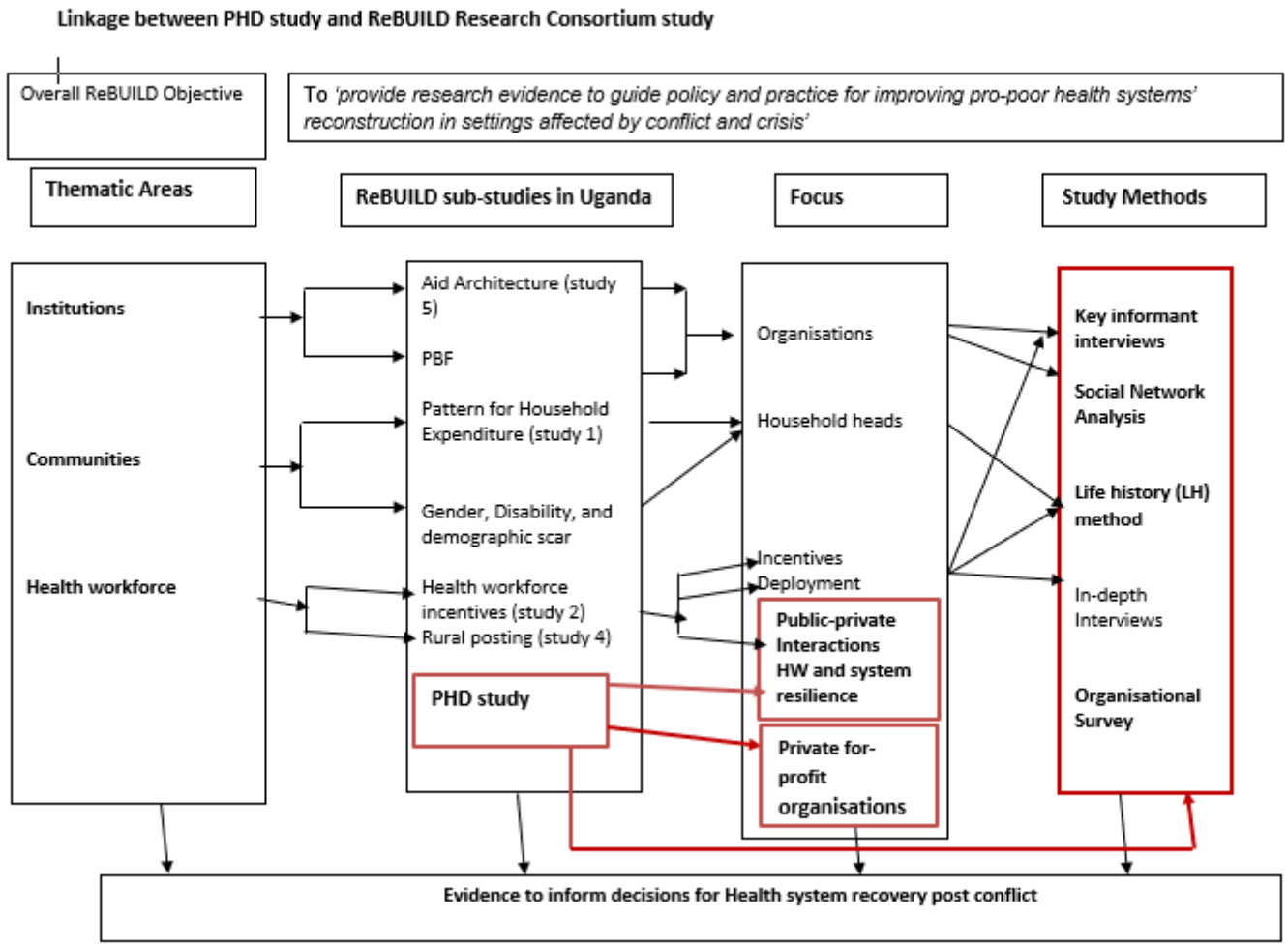
[2] The studies with * had no numbers assigned to them. The rest of the studies had been assigned numbers 1, 2,4 and 5.

4).[3] This PhD study can be considered as the seventh study conducted in Uganda under ReBUILD Consortium.

The next section elaborates on the contribution of this PhD study to the overall ReBUILD Consortium objective. Figure 2 illustrates the focus and methods of all the seven ReBUILD sub-studies in Uganda (including the PhD study). The areas related to the PhD study are marked by the maroon-red boxes and arrows. Figure 2 also shows that there was an overlap between the intersection with the health workforce studies in relation to the general focus area. The PhD study also built upon methods used in the six ReBUILD sub-studies.

[3] For more details see http://rebuildconsortium.com/ and https://rebuildconsortium.com/media/1689/rebuild_summary.pdf

Figure 2: Linkage between PhD study and ReBUILD Consortium research studies in Uganda



First, this PhD study aimed at filling an information gap on the private for-profit sector within the main ReBUILD studies. Whereas the other ReBUILD studies undoubtedly provided invaluable evidence on health systems during recovery, the focus on the private for-profit (PFP) sector was largely limited. Specifically, the studies focused on PNFP sector as compared to the public sector (Studies 2 and 4) and non-governmental organisations (NGOs) as supporters of the district health team in the provision of health services (Study 5). The findings of Study 1 only indicated that the private sector was part of the wider pool of providers in the market from among which the patients would choose. Therefore, this study provided some evidence about the private for-profit sector and the communities' perspective on its role but was ultimately limited in its focus on that sector, yet is central to the debate about the provision of equitable and pro-poor health services in settings recovering from conflict.

Second, this study aimed at bringing out an organisational perspective which was limited in the ReBUILD studies. The research observed that the studies, except for the aid architecture sub-study (Study 5), focused on the individual and households as units of analysis rather than on organisations.

Furthermore, this study built on the experience generated using methods previously used within the ReBUILD Consortium research, for instance life history methods and social network analysis. For instance, three of the ReBUILD Consortium studies utilised the life-history interview method. Study 2 used the life history method to understand health worker experiences and coping strategies with incentive policies during and after conflict (Witter et al., 2017); Study 1 used the life history method,

among other methods, to analyse healthcare-seeking patterns in households in Gulu district, Northern Uganda (1962-2013) (Fustukian et al., 2017). The third study used life-history interview methods to assess the impact of conflict on gender and the demographic scar.

Additionally, the aid architecture study (Study 5) had utilised social network to map the organisational infrastructure for service delivery in post-conflict Northern Uganda (Ssengooba et al., 2017). In this PhD study, social network analysis was used to generate network maps as illustrations for linkages and relationships between FPFPs and other organisations in the market.

b) Fieldwork experiences and the need to interrogate the booming private sector

My experience as a coordinator for ReBUILD Uganda provided me with a forum through which I was able to observe many things. During my stay in Gulu municipality, and on many of the field visits for ReBUILD studies, I used to take evening walks around the town and observed that there were many private for-profit health providers. Given my prior knowledge of the context and the poverty levels, I became curious about how these providers came to set up, survive and cope with the challenges. Therefore, I decided to conduct an exploratory investigation through this doctoral study to understand the subject.

c) The aspiration to contribute to ongoing global and national debates

Lastly, I was motivated by the desire to contribute to ongoing global and national debates about the private for-profit sector, through the provision of voices and experiences from the formal private for-profit providers in Northern Uganda. The next section elaborates on some of the debates.

1.2. Target Audience

The target audience for this research includes policymakers at the national and sub-national levels (MOH, professional associations, district health offices), multilateral development health organisations (such as the United Nations [UN], the World Bank and the World Health Organisation [WHO]), members of academia and think tanks for UHC. The study will not only contribute to the available knowledge to enrich the debate on the contribution of the FPFP to pro-poor and equitable health service delivery but also to UHC through the provision of information on what factors influence this contribution. This will provide policymakers, donors and implementers with evidence of how to tap into the potential of such providers to help communities by expanding the provision of health services to them as well as offering an alternative to public provision that may be weak, especially early in post-conflict settings.

1.3. Study Aim and Research Questions

Overall study aim

To understand the extent to which FPFPs have contributed to an equitable/pro-poor health system in post-conflict Northern Uganda

Main research question

To what extent have FPFPs contributed to the promotion of an equitable/pro-poor health system in post-conflict settings such as Northern Uganda?

We need to understand the factors that influence/have influenced this 'contribution' over time. These are broken down in into four specific objectives/research questions

Sub-questions

1. a. What are the characteristics of the FPFPs in Northern Uganda?

   b. How have the FPFPs evolved during and after the conflict?

2. What are the dynamics of the healthcare markets in which these FPFPs operate?
    a. What are the challenges faced by FPFPs within the market?
    b. How do these organisations negotiate these markets (what are the coping strategies)?
    c. What opportunities does the post-conflict period present for the FPFPs in Northern Uganda?
    d. What is the relationship between FPFPs and other health providers and health development partners in Northern Uganda?
3. a. What mechanisms, if any, do FPFPs employ to ensure that the poor access healthcare in a post-conflict environment?

    b. How does the interaction/relationship between FPFPs, other health providers and health development partners influence their contribution to an equitable and pro-poor health system?
4. What recommendations or suggestions are derived in relation to encouraging FPFP to adopt a pro-poor health agenda?

1.4. Organisation of the Thesis

Chapter 2 contextualizes the private sector within the broader development goals. The chapter also provides a theoretical background to the existence of the private sector. In addition, it indicates how neo-liberalism and the Washington consensus provided a background to the development of the private sector. The chapter then presents a review of literature about the private sector in general, while noting the types and broad and present characteristics of the private sector in post-conflict settings. Chapter 2 then presents a discussion on the market and highlights the major

issues related to the price mechanism and demand. Finally, the theory of New Institutional Economics (NIE), which indicates its connections and variations with classical economics as well as its application in this study, is introduced.

Chapter 3 provides a contextual background to Uganda and Northern Uganda. The effects of neo-liberalism on health systems in Uganda as well as regulation and partnerships with private sector actors are presented. The chapter also presents a brief overview of the conflict in Northern Uganda and its effects as well as the socio-demographic indicators for Northern Uganda. The actors in the healthcare market in Uganda/Northern Uganda and their roles are presented. At the end of Chapter 3, which is the last chapter for the literature review, the researcher presents the conceptual framework that guided the study.

Chapter 4 presents the study methodology, indicating the broader epistemological and ontological views guiding the study, and notes that the study was informed by the pragmatic view. The researcher then presents the justification for choosing mixed methods for the single holistic case study. The boundaries of the case study and details of Gulu district as the study setting are described. The chapter also presents the data collection methods, data management and analysis process as well as the ethical considerations.

Chapter 5 presents the findings related to the first research objective and is divided into two parts: 5.1 focuses on the characteristics of FPFPs in Gulu municipality, whereas 5.2 focuses on how the FPFPs have evolved during and after the conflict. The analysis for this chapter draws on constructs from neo-liberal theory (proliferation

and free entry), the concept of evolution of organisations as well as NIE-related concepts such as sunk costs and credible commitment, among others.

Chapter 6 presents findings related to the second research objective, the challenges, and coping strategies for FPFPs during and after the conflict and presents the opportunities. The analysis in this chapter draws on the concepts of evolution, resilience, NIE-related concepts of sunk costs, credible commitment, transactional costs, and uncertainty. The chapter emphasizes that the FPFPs experienced many challenges against which they innovated coping strategies. The chapter also illustrates that amidst the post-conflict challenges, various opportunities appeared and the FPFPs had to take advantage of such opportunities to enter the market or survive the market challenges.

Chapter 7 presents the findings about the relational links between the FPFPs and other providers and other organisations within the market. The links are illustrated using social network maps. The analysis of the data for this objective was mainly based on the NIE concepts of networks as a form of markets and contracts. The main argument in this chapter is that FPFPs are interdependent and connected with other organisations and thus also emphasizes the blurry nature of the boundaries between FPFPs and other organisations, including the public facilities.

Chapter 8 presents the findings related to research objective three. It presents innovations around the identification of the poor and the mechanisms employed by the FPFPs to ensure pro-poor access. The chapter also highlights ways in which relationships between FPFPs and others enable its contribution to enabling access

for the poor. While analyzing this data, the researcher reflected on the neo-liberal assumption of profit maximization while also highlighting aspects of social entrepreneurship theory.

Chapter 9 presents a discussion of the main findings of the study in the context of the existing literature about private sector characteristics, resilience, linkages to other providers/organisations and its contribution to UHC. The researcher revisits the initial conceptual framework while considering the findings and indicates the revised conceptual framework. Furthermore, the researcher reflects on patterns of behaviour observed in private providers that are particularly characteristic of post-conflict settings, while noting, where possible, the outstanding similarities with settings that are relatively stable. The researcher then reflects on the limitations as well as the strengths of the study and then draws conclusions and recommendations based on the empirical findings. The conclusion draws on the researcher's position in relation to the ideological poles of debate (for and against) on the role of the private sector in UHC. Lastly, the researcher summarises areas for further research and action.

CHAPTER 2: GLOBAL COMMITMENTS, NEO-LIBERALISM, PRIVATE SECTOR, PUBLIC-PRIVATE MIX AND THE MARKET

2.0. Introduction

This chapter begins with a brief description of the global commitments to health – UHC and SDGs – as part of the wider context that not only sparks debates but also promotes harnessing the private sector as a key partner in health. The place and areas of contribution of the private sector within the wider context are described using the UHC cube. Next is a section on neo-liberalism as the main ideology informing the establishment of the Washington Consensus/prescriptions which informed the introduction of Structural Adjustment Programmes (SAPs) and later promoted the withdrawal of the state from health service provision while favouring the private sector. The section analyses and questions the overall intention of the Washington Consensus and indicates the key effects on the health sector.

The next section starts with a broad description of the private sector and delves into elements of heterogeneity, which are used to distinguish one section of the private sector from another. The next section is brief and presents factors that enable the existence and expansion of the private sector, with the main argument being that the public sector is mainly to blame. The roles of context and regulation are also indicated as contributory factors. Next, the researcher reflects on the question of the public-private mix, which indicates and enforces the idea of the blurred boundaries between the public and the private sector. The section ends with recommendations, including

a clarification of roles for both the government and the private sector. The researcher then presents a brief description of potential interventions for engaging the private sector within the public-private mix.

Next is a section describing the private sector in post-conflict settings, while noting the key characteristics and challenges. This is followed by a section about the market and the related concepts, such as the price mechanism and its roles. The section then delves into an understanding of demand in general while also indicating the determinants of demand. This section narrows down the discussion to the demand for healthcare and highlights the differences and similarities between demand for healthcare and demand for other goods. Then, finally, the theory of NIE is introduced, indicating its connections and variations with classical economics and how it was applied in the study.

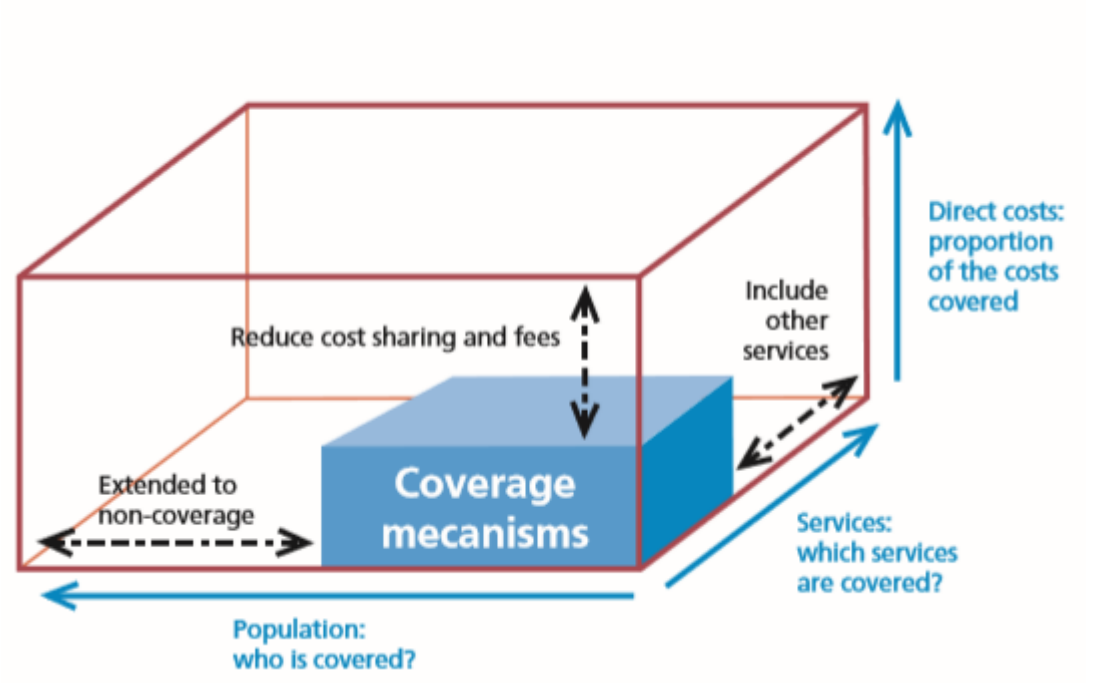
2.1. Global Effects in Relation to UHC and SDGs

First, let us look at UHC, MDGs and SDGs and the linkages between the three platforms for discussion about the targets and highlight where these platforms recognise the role of the private sector as a whole and the private sector in post-conflict settings. Countries all over the world have had a centuries-long interest in the health outcomes of their people. This could be because health, as indicated by WHO, is ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’ (WHO, 1946). Implied in this definition, therefore, is the central connection between health and all other aspects of a person’s life.

As a result, deliberate efforts have been made to join global interventions and movements targeted towards the improvement of health and access to health. These include becoming signatories or at least keen followers of the Alma Ata Declaration of 1978 (Alma Ata Declaration, 1978), UHC and later the SDGs. UHC was introduced in 2010 as a vehicle for advancing the progress that countries had made in relation to the MDGs with the target to achieve them by the year 2030 (WHO, 2013). UHC has three goals: quality, protection from financial risk and increasing access for all (WHO, 2010b, WHO, 2013). Hence, in relation to the MDGs, UHC implied open access for all to health services, and involves strengthening efforts to improve the quality, availability and affordability of services (WHO, 2013).

The measurement of UHC is illustrated by the famous UHC cube in Figure 3 (WHO, 2010b). The cube has three dimensions which help in understanding whether UHC is achieved or not – the population served, the costs of services and the quality of services – and all these are interrelated. For instance, to understand whether UHC has been achieved, one can look at the proportion of a population that can access essential quality health services and the proportion of the population that spends a large amount of household income on health. However, for UHC to be achieved, all the three dimensions must be maximised (McPake and Hanson, 2016). Little is known about the extent to which the for-profit private sector tries to contribute to the maximisation of the three dimensions in conflict settings. Figure 3 illustrates the three dimensions of the UHC cube.

Figure 3: The UHC cube indicating dimensions for measuring UHC



Source: (WHO, 2010b)

In September 2015, the SDGs were unveiled.[4] The SDGs proposed 17 sustainable development goals with 169 associated targets and are based on fundamental principles such as economic development, environmental protection and social equity and are part of the Global Agenda 2030 for Sustainable Development.[5]

The WHO and other advocates for the SDGs have underscored the centrality of health to all the other 16 SDGs and have indicated this both in word and in illustration.[6] Health is indicated as SDG 3 and it has nine targets: three that continue from the MDGs; three that are related to non-communicable diseases (NCDs) and injuries; and three that are cross-cutting or focus on systems encompassing UHC, universal

[4]https://www.un.org/sustainabledevelopment/sustainable-development-goals/
[5]https://sustainabledevelopment.un.org/sdgs
[6]https://www.who.int/sdg/en/

access to sexual and reproductive healthcare services, and also on reducing hazards from air, water and soil pollution.[7] SDG 17, which focuses on partnerships, has also been emphasised as key to achieving SDG 3. This was informed by the realization that UHC requires policy actions in a complex and increasingly multi-sectoral approach (Rasanathan et al., 2017).[8]

As McPake and Hanson (2016) note, the goal of UHC as outlined in the SDGs provides a renewed focus on the need to take a systems perspective in designing policies to manage the private sector (p.622).

The next section introduces us to how this private sector came to exist. Neo-liberalism exaggerates the advantages of the private sector which, over time, have come to be debatable and have, in practice, not yielded any positive results for the populace and for the health sector.

2.2. Background to the Existence of the Private Sector

2.2.1. Neo-liberalism and its assumptions

Neo-liberalism is a core ideology that has driven the development of the private sector worldwide in recent decades. Neo-liberalism is a theory based on Adam Smith's classical economic theory. Together with other 19th century classical economists, Adam Smith believed that economic growth could only be stimulated and sustained if private individuals could pursue their self-interest unhindered by the state (Clarke,

[7]https://www.who.int/sdg/targets/en/
[8]Rasanathan et al 2017. IHP + for UHC 2030.Multisectoral working group. Work plan 2017-2918.https://www.who.int/social_determinants/IHPplus-for-UHC2030-multisectoral-action-working-group-workplan-Sept2017.pdf?ua=1

2005). In his highly acclaimed book, *The Wealth of Nations*, Smith (1776) suggested that, left on its own, capitalism would operate on a rationality that makes possible the transformation of individual selfish interests into public virtue. As Harvey (2005) in (Thorsen, 2009) reiterates:

> Neo-liberalism is in the first instance a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterised by strong private property rights, free markets and free trade. (p.11)

There are thus three main assumptions of neo-liberalism: 1) Individualism; 2) a free market; and 3) decentralisation/a minimal or reduced role for the state (McGregor, 2008).

i) *Individualism*: Neo-liberalism assumes that human beings will always try to favour themselves and, as they do this, will have no concern for others or for the environment (Martinez and Garcia, 1997). Implied in this assumption is the inherent greed and selfishness among individuals and the tendency to accumulate as much property or wealth as possible and to maximize profits. This is in line with the adage of 'survival of the fittest' (Gregory, 2000). Scholars such as Bandy (2000) and Martinez and Garcia (1997) replace the concepts of the public good and the community with individual responsibility. This implies that in the absence of government intervention, persons are expected to cater for their basic needs regardless of whether they can afford to or not. Furthermore, this concurs with Harvey's definition of neo-liberalism indicated earlier at the beginning of this sub-section (2.2).

ii) *Free market*: In order to 'free up markets' so that they can 'grow' the economy, neo-liberalism requires that the market be freed from government regulation

(Stiglitz, 2002); hence the prices are determined by the forces of demand and supply (McGregor, 2008), a situation that is also termed the 'price mechanism'. Again, Harvey (2005) in (Thorsen, 2009) explains:

> State interventions in markets (once created) must be kept to a bare minimum because, according to the theory, the state cannot possibly possess enough information to second-guess market signals (prices) and because powerful interest groups will inevitably distort and bias state interventions (particularly in democracies) for their own benefit. (p.11)

The free market is emphasised as playing a role in achieving both individual well-being as well as a more trusted role in allocating resources. According to (Thorsen, 2009), neo-liberal proponents argue thus:

> Free markets and free trade will, it is believed, set free the creative potential and the entrepreneurial spirit which is built into the spontaneous order of any human society, and thereby lead to more individual liberty and well-being, and a more efficient allocation of resources. p.14

Hence, there is free entry for firms as well as 'perfect competition'. Free entry may also result in the presence of large numbers of organisations in the market, but these can be regulated by the competition. The private organisations also could be flexible and explore various alternatives.

iii) *Decentralisation*: Decentralisation or devolution means the transfer of central powers, responsibilities and accountability to lower levels (regional and provincial authorities) to ensure efficiency(McGregor, 2008, Bergh, 2012). According to Bergh (2012: 309)), decentralisation 'meant shifting mandates and tasks (and hopefully funding) to multiple levels, regional, state/provincial authorities to ensure effective allocation of resources.'

Bergh (2012) Adds that horizontal disaggregation to the NGOs and the private sector came in addition to the vertical disaggregation of the state (ibid.). However, Joshi (2008: 11) in Bergh (2012) emphasize:

> Allowing state and non-state providers to flourish at the local level, the invisible hand of the market was expected to cater to a greater diversity of needs, allowing users to choose providers that best meet their needs in terms of price and quality.

In the Mediterranean countries, for example, the competition among the increasing numbers of (private) providers and the variety of services they provided enabled users to exercise choice (Bergh, 2012).

Bergh's critique of neo-liberalism, however, is that perfect competition is absent, especially in poor and rural areas, where there is often no effective competition and users do not have adequate information about the true quality of services (ibid.) (Bergh, 2012).Overall, Guazzoni and Pioppi (2009) in Bergh (2012) state that neo-liberal reforms such as decentralisation contribute to the displacement, relativization and reconstruction of the borders between the 'public' and the 'private'.

2.2.2. Neo-liberalism, the Washington Consensus, and its implications for the healthcare system

The Washington Consensus provides the best framework for understanding the effects of neo-liberalism, particularly in relation to increased privatisation globally. The term Washington Consensus was coined by Williamson in 1989 in reference to a set of ten neo-liberal policy prescriptions which had been proposed, and later supported, by the influential Washington-based institutions (Williamson, 2004). These institutions

include the International Monetary Fund (IMF), the World Bank, the US Treasury and the World Trade Organisation (WTO) (Williamson, 2004, Stiglitz, 2002).

These prescriptions were developed initially to respond to the economic crisis in the Latin American economies of the late 1980s. However, they were recommended later for implementation in the rest of the developing and less developed countries, including those in Africa. The ten propositions/neo-liberal reforms are hereby summarised (Williamson, 2004):

1. The imposition of fiscal discipline.
2. The redirection of public expenditure towards other fields.
3. The introduction of tax reforms that would lower marginal rates and broaden the tax base.
4. The liberalisation of the interest rate.
5. A competitive exchange rate.
6. The liberalisation of trade.
7. The liberalisation of inflows of foreign direct investment.
8. The privatisation of state-owned economic enterprises.
9. The deregulation of economic activities.
10. The creation of a secure environment for property rights.

Although the 10 principles mentioned above imply a lot of freedom, Stiglitz (2002) argues that it was actually ‘managed trade’ for the corporate and financial benefit of the Bretton Woods institutions and no freedom at all for the developing countries (previously referred to as Third-World) (Stiglitz, 2002). Accordingly, as Lensink (1996) in Ssali (2018) indicates, healthcare reforms implemented in many developing

countries as part of SAPs reflected a top-down translation of these neo-liberal prescriptions by the World Bank.

The overall objective of the SAPs in the health sector was to improve cost effectiveness and effectiveness and efficiency (Ssali, 2018). The World Bank report entitled *Investing in Health* attributes the so-called inefficiencies and ineffectiveness within the health sector to four causes: a) misallocation of resources; b) insufficient spending on cost-effective health activities; c) internal inefficiency of public programmes; and d) inequity in the distribution of benefits from health services (World Bank, 1993). Therefore, neo-liberalism favoured the private sector over the public.

Kentikelenis (2017) identifies three main pathways along which SAPs affect health: policies directly targeting health systems; policies indirectly affecting health systems; and policies affecting social determinants of health. She further underscores the relevance of such pathways to the experience of SAPS by countries across time and space (Kentikelenis, 2017).

The effects notwithstanding, for this study, neo-liberalism and the Washington Consensus provide an insight into the emergence of the private sector in general, as well as its characteristics and behaviour (for instance, profit maximisation, free entry, flexibility and proliferation).

2.3. The Private Sector

The private sector is defined in varied ways. The private sector refers to all providers outside the public sector (Patouillard et al., 2007), those not owned by the state

(Birungi et al., 2001) or all non-state actors (Clarke et al., 2019) involved in health or the totality of privately-owned institutions and individuals providing healthcare (Mackintosh et al., 2016). The private sector is generally large and homogeneous (Mackintosh et al., 2016, Clarke et al., 2019, Birungi et al., 2001, McPake and Hanson, 2016). This heterogeneity also exists within a given category, for instance the not-for-profit providers, as well as within the for-profit providers (McPake and Hanson, 2016).

The distinction within the private sector is often limited to a broader dichotomy: private not-for-profit and for-profit (Morgan et al., 2016). The private not-for-profit providers include mission facilities and NGOs. On the other hand, the for-profit providers include individual clinical practitioners, corporate hospital chains and international private insurers, itinerant medicine sellers and pharmacies (Mackintosh et al., 2016). They also include drug shops, market vendors, home providers and traditional healers (Birungi et al., 2001).

McPake and Hanson (2016) present a table with three major dimensions, which can be used to achieve an understanding of heterogeneity and therefore differentiate the private sector. These include objectives, the size of organisations and quality (using proxies of qualified or unqualified front-line staffing) (p.623). However, in their write-up, they add other dimensions such as ownership, source of funding and formalization (licensed or unlicensed).

Profit related objective: Not-for-profit and for-profit

The private not-for-profit(PNFP) sector is perceived as one that has a social mission and is, therefore, set up to deliver a social value to the underserved (Abu-Saifan, 2012). Furthermore, the PNFP sector is assumed to offer more financial protection compared to the for-profit sector but also to contribute to the delivery of health services with no financial gain (Morgan et al., 2016). The PNFPs include networks of NGOs and faith-based providers which operate as diocesan provider networks (McPake and Hanson, 2016). Given their ownership by the church, the latter were described as 'working for God' (Reinikka and Svensson, 2003).

The for-profit sector, on the other hand, as in its name suggests, is perceived to set out with the aim of maximizing financial gain/profit for shareholders, partners (Morgan et al., 2016) or individual owners. In Uganda, the private practitioners have previously complained about the 'for-profit' tag, considering it demeaning, given that it implies that their cardinal role is making profit. Instead, they proposed that they be called 'patient funded practitioners' (Birungi et al., 2001).

The above complaints bring to light the discussion about whether the for-profit sector may not be making profit as generally assumed or whether the PNFPs make profit. Some scholars have noted that the FPFP sector indeed makes profit, but that, unlike their colleagues in the for-profit sector, they reinvest the surplus to improve the quality, scope and volume of services or expand the infrastructure required for services (McPake and Hanson, 2016, Tumwesigye, 2013)

However, McPake and Hanson (2016) argue that both the private for-profit and the PNFPs are exposed to market forces through which survival is reliant on revenue generation. Hence, the surplus is reinvested by PNFPs to address private interests rather than the public good. The act of charging user fees when there is already a subsidy from the government or other donors puts PNFPs in the same position as the for-profit sector (ibid.). This was one of the causes of mistrust of the PNFP sector, and a major challenge facing the government-PNFP relationship in Uganda (Ssennyonjo et al., 2018).

In contrast, Abu-Saifan (2012) argues that within the boundaries of social entrepreneurship, both the PNFP and for-profit providers have the potential to swing between making profit and acting for a social value (p.26). For instance, Figure 4 illustrates the possibility for a social enterprise (such as the PNFP) to perform a hybrid activity that is both social and commercial in nature for purposes of self-sufficiency, still with profits being reinvested in the social value. Furthermore, as entrepreneurs, the private for-profit sector can also have a social mission (ibid., p.27). As Filipe and Santos (2012) in (Abu-Saifan, 2012) indicate, this can be done by the invention of new products and services and hence the deployment of new business models to address basic human needs (ibid.). However, social entrepreneurs are advised to strike a balance between the social and economic/profit-making objectives (Abu-Saifan, 2012). Consequently, the study sought to understand whether the FPFPs could have any innovations in place that are targeted towards social value creation.

Figure 4: Boundaries of social entrepreneurship – Adapted from Abu Saifan (2012)

Quality

Morgan et al. (2016) present three main types of quality. The first is service quality, which is reflected by the responsiveness of staff and often measured by patient satisfaction. The second is technical quality, which refers to the competence level of providers and their ability to adhere to clinical guidelines (p.607). The third is structural quality, which relates to buildings, equipment, materials and drug availability as well as quality of delivery (ibid. p.608). Morgan et al. (2016) further note that PNFPs were better than for-profit in relation to structural quality while for-profit providers had a comparative advantage in achieving patient satisfaction. However, in contrast with the public sector, the two sub-sectors performed worse regarding technical quality (ibid.).

Size of organisations

Private organisations also vary in size, ranging from large to small. The size is most related to the square metres covered by the building in which the provider operates.

For instance, a corporate hospital chain (Mackintosh et al., 2016) is much larger than a drug shop.

Ownership

A section of the PNFPs, particularly the NGOs, may be owned by a group of people; whereas in the mission sector, the facilities are owned by dioceses (Birungi et al., 2001). Some of the for-profit sector is owned by individuals, who are sole entrepreneurs, and these, in some countries such as India, form a substantial share of the private sector or even form the bulk of the private sector (Mackintosh et al., 2016).

Source of funding

The funding for many the not-for-profit providers comes from external sources. For instance, the majority of the NGOS normally get their funding from donors whereas the mission not-for-profit sector is largely funded by donors, substitutes by government through financial and non-financial resource contributions/subsidies and, in most cases, also charge a subsidized fee (McPake and Hanson, 2016, Ssennyonjo et al., 2018).

The funding for many of the not-for-profit providers is based on the type of ownership. For instance, in group-owned entities, the stakeholders contribute funding, while in sole-owned businesses, the owner provides start-up from their savings. However, among the corporate commercial providers, which are a relatively new phenomenon, investment is made by international development agencies such as International Finance Corporation, the investment arm of the UK Department for International

Development (DFID) and CDC Group (McPake and Hanson, 2016). In their reports, these agencies have boasted of collaborating with the private sector to improve people's lives (International Finance Corporation, Undated) and the Harnessing Non-State Actors for Better Health for the Poor (HANSHEP) Scheme (DFID, 2013). However, critics have argued that private providers increase inequality and their investments further undermine countries' investments in UHC and public health in general (McPake and Hanson, 2016)

Formalisation

This applies to both the for-profit and not-for-profit private sectors. In relation to the not-for-profit, being registered restricts (at least on paper) them from the distribution of the surplus as profit (McPake and Hanson, 2016, Birungi et al., 2001).The for-profit sector is further divided into formalized (licensed) and non-formal (unlicensed). In this case, the degree of formalization is merely determined by registration with the authorities (Birungi et al., 2001). Formal private for-profit healthcare organisations (FPFPs) are formalized (registered/licensed) commercial organisations and individuals that deliver health-related services with the main objective of accumulating profit (Institute for Health Sector Development, 2004, Bloom et al., 2013).

Informal providers (IPs) are those that operate outside the formal rules regulating the practice and conduct of health workers (Standing et al., 2013). However, they may be legitimized and appreciated by communities and even, in some instances, intentionally ignored by regulators, for fear of risk to their lives by the communities (Birungi et al., 2001). Unlike their counterparts, the FPFPs, IPs possess little or no formally recognized training with a defined curriculum from an institution; collect payments which are often undocumented; are not registered with any government

regulatory body; and rarely have professional affiliation (Lagomarsino, 2013, Sudhinaraset et al., 2013).These include drug sellers within the confines of shops and clinics, drug vendors, traditional birth attendants (TBAs), traditional healers, village doctors, unregistered pharmacists, bonesetters and herbalists (World Bank., 2003).

Table 1: Dimensions of heterogeneity among private sector actors

Provider type	Size	Quality	Ownership	Having infrastructure	Ownership	Source of Funding	Formalisation
Not-for-profit	Large, e.g. network of NGO providers Small, e.g. faith-based clinic	Qualified Unqualified	Network of NGO providers Diocesan facilities	Facility-based, e.g. diocesan facilities Non-facility-based: Some NGOS	Individuals Formed by an individual Group: NGO networks, diocesan facilities	Donor funding and charity	Licensed
For-profit	Small, e.g. sole practitioner Large, e.g. corporate chains Small – drug shops, iterant drug vendors	Qualified, e.g. sole practitioners and larger corporate providers Unqualified: Low quality underqualified providers	Small: Individual Larger for-profit	No infrastructure, e.g. private insurers	Individual Multiple shareholders	-Individual or multiple share - International donor agencies (for the case of the corporate providers)	Formal for-profit providers: Licensed/registered Informal for- profit Providers: Unlicensed/Unregistered

Source: Adapted from McPake and Hanson, 2016.

The above characteristics notwithstanding, the study sought to understand the characteristics of the FPFPs within Gulu municipality and how these providers evolved and had their characteristics change over time.

2.3.1. Factors shaping the differences in the private sector

The diversity of the private sector within countries is due to three factors: the changing characteristics and performance of the public sector; deregulation; and the context

within countries. Mackintosh and colleagues have argued that in many low-income countries, the diversity of the private sector is shaped by the changing characteristics of the public sector, driven by deregulation (Mackintosh et al., 2016). Using case studies from Ghana, Malawi, Tanzania, and Nepal, they illustrate that higher-end private facilities are perceived to offer superior care in contrast with the failings of the public sector. Furthermore, they argue that deregulation has allowed smaller-scale and poorer-quality providers to multiply (ibid.) It has also been widely documented that the accessibility, convenience (shorter waiting times) and flexibility (in opening times) (Benjarattanaporn P. et al., 1997, Uplekar et al., 1998, Smith et al., 2001, Rutebemberwa et al., 2009, Bloom et al., 2011) of the particularly small private sector providers make them attractive compared to the public sector alternatives. Other factors that make the private sector more attractive than the public sector include cleanliness; increased time spent with the doctor and (perceived) better availability of staff (Morgan et al., 2016). Some countries, such as Nigeria and India, have a dominant private sector in both primary and secondary care. This is due to the scarcity of public sector availability (Mackintosh et al., 2016).

Proponents of the private sector have argued that the sector plays an important role (Konde- Lule et al., 2010), therefore, it should be harnessed to ‘fill the gap’ left by the public sector (Decosta and Diwan, 2007) or ‘left’ by the state to continue its role in health service provision. Some have even provided ideas on the creation of meaningful collaboration(s) between the public and private sectors for health service delivery (IHEA, 2009). These include insurance and strategic purchasing (WHO, 2010b).

Critics have warned about and documented undeniably ‘fast’ but ‘scary’ growth/ expansion of the private sector, particularly in LMICs’ health systems (Doherty, 2011, IHEA, 2009, Marriott, 2009). In fact, Doherty has emphasised the need to regulate growth and quality as well as the ‘best’ ways to do this in the private sector and further warned of how for-profit providers can thwart government efforts to regulate the private sector in East and Southern Africa (Doherty, 2013). Others have argued that the involvement of the private sector is a ‘disservice’ to the broader agenda of achieving UHC (Marriott, 2009, Marriot and Ndour, 2013). This is because it increases health expenditures among the poor or discriminates against them. It is also more likely to make compromises about quality (ibid.).

Furthermore, critics such as Marriot and Ndour (2013) have dismissed advocates of the private for-profit health sector as being merely *‘blindly optimistic’*, implying that the private sector offers no escape from the challenges facing public health systems in developing countries. As laid out by Clarke et al. (2019), these challenges include limited fiscal space for the health sector, an increase in disease burdens, particularly NCDs, as well as demographic shifts, including ageing, displacement and political and economic instability (p.434).

Simply put, the private sector cannot replace the public health system because it has its own challenges that need fixing first (Marriot and Ndour, 2013). First, investment in the private (health) sector is expensive and can increase inequity of access to health services. In LMICs, private sector financing is heavily dependent on out-of-pocket (OOP) expenditure as the main funding source (International Finance Corporation, Undated). In fact, some scholars have referred to the private sector as the patient-funded sector (Birungi et al., 2001). As indicated by Xu et al. (2003) and

Mackintosh et al. (2016) in McPake and Hanson (2016), this often results in catastrophic health expenditures that sustain poverty levels. Secondly, the private sector is also experiencing performance gaps. As noted by Morgan et al. (2016), the heterogeneity of the private sector complicates assessment of the performance of the private sector, particularly in relation to quality of services. Morgan et al. (2016) note that, in contrast to the public sector, the technical quality within the private sector is largely low (ibid.). As indicated by Basu et al. (2012) in Morgan et al. (2016), poor quality in the private sector was reflected in diagnostic inaccuracy, increased incidence of unnecessary procedures such as caesarian sections as well as poor adherence to medical management standards and prescription guidelines (Morgan et al.2016: p.388). Studies conducted in Nigeria and Vietnam attributed the rise in drug-resistant malaria to poor adherence to prescription guidelines by private providers (ibid.). Nevertheless, some private providers, for instance the corporate commercial providers, have been reported to maintain some quality standards (McPake and Hanson, 2016). Lastly, given the difficulties in regulating the private sector, there is also no evidence that the private sector can be more accountable or fraud-free than the public sector (Marriot and Ndour, 2013).

Context also determines differences in the private sector. McPake and Hanson (2016) note that the nature of the private sector is largely shaped by differences in country contexts specifically based on political, socio-economic, demographic and historical drivers of health system performance (McPake and Hanson, 2016).

2.4. The Public-Private Mix, Roles and Examples of Private Sector Interventions

A key issue highlighted in the write-up above is the debate about whether the public and the private sectors are different or part and parcel of the same entity or lie along a continuum. Patouillard et al. (2007) note that, in practice, the boundaries between public and private provision may be blurred. To some scholars this implies dual practice, where some practitioners work in both sectors or even provide services in the public sector facility premises at a fee (Birungi et al., 2001, McPake et al., 1999). In recognition of this complexity, some scholars have recommended some workable solutions.

Birungi et al. (2001) recommend that instead of stressing the differences, there is need to appreciate the public-private mix and, therefore, to promote the comparative advantages of each sector (Birungi et al., 2001). Within this public-private mix, the functions of the public and private sector need to be clear. They state that:

> The comparative advantage of the private sector lies in service delivery, providing diversity, choice, and innovation and in technical efficiency to render services. They also have potential to address equity. The comparative advantage of the government is the ultimate responsibility for health and wellbeing of its citizens, leadership and policy development, regulation, financing health services, promotion of public health and response to disasters. They also provide finances. (pp. 85-86)

McPake and Hanson (2016) also call for a recommitment on the part of governments to health system outcomes as a prerequisite for the achievement of UHC. They recommend that

> Achievement of Universal Health Coverage requires pooled, mainly public financing, but can be compatible with various roles for private health providers under effective public stewardship. (pp.628-629)

In line with Birungi et al. (2001), McPake and Hanson (2016) also highlight the regulation of the private sector as another crucial role of the government and their proxy bodies. Regulation of the private sector has two main purposes: 1) ensuring that public resources are not misdirected to private users; and 2) ensuring that users of private services are not exploited through the provision of unnecessary or unsafe care, excessive claims and excessive charges (McPake and Hanson 2016:628). Ensuring adequate quality of services provided is also another purpose of the regulation of the private sector (Conteh and Hanson, 2003). As indicated by Patouillard et al. (2007), this may take the form of rules as well as enforcement and sanction mechanisms whose implementation and focus are determined by the level of healthcare provider, organisation and facility. For example, at organisational level, the focus of regulations may be on control of the location of facilities, their registration and the minimum number of staff or facilities (Conteh and Hanson, 2003). However, at facility level the focus of regulation may range from requirements for pre-service training and continuing education to licensing and certification of providers (Waters et al., 2003).

In addition to regulation, Patouillard et al. (2007) describe other interventions where the government works with the private sector, particularly the for-profit providers. These include social marketing, the use of vouchers, pre-packaging, franchising, contracting out accreditation and training (Patouillard et al., 2007). However, there is also the possibility of creating a package of more than one intervention.

Social marketing refers to the application of tools and concepts of social marketing to social and health problems in order to increase population coverage and affordable

interventions (Kikumbih et al., 2005). Examples include health promotional activities, branding, labelling, pre-packaging and subsidy of public health products (Patouillard et al., 2007). Among other purposes, social marketing has been successfully used in encouraging the use of condom use in Cameroon (Van Rossem and Meekers, 2000), the coverage of iron-folic supplement among non-pregnant women in the Philippines (Paulino et al., 2005) and increasing coverage of insecticide-treated nets (ITNs) for children under two years in Tanzania (Abdulla et al., 2001).

A voucher is a form of subsidy that the recipient can use as part or full payment for a product or service for identified providers (Patouillard et al., 2007). Vouchers can be demand side, where the voucher is given to service users or where the providers get the vouchers to deliver an agreed service, or a mix of both demand and supply sides (Ekirapa- Kiracho et al., 2011). The use of vouchers has been successful in relation to reproductive health services in Kenya and Uganda (Bellows, 2012) and in Nicaragua (Meuwissen et al., 2006). In Uganda, supply- and demand-side vouchers were used to mitigate the access barrier related to distance while increasing facility-based deliveries and ultimately reducing maternal mortality (Ekirapa-Kiracho et al., 2011, Alfonso et al., 2015). However, vouchers can also be competitive (Meuwissen et al., 2006) or non-competitive (Marek et al., 2005), where the former involves exchanging a voucher at more than one facility and the latter involves assigning the voucher to one provider (Patouillard et al., 2007).

Pre-packaging is a strategy to improve provider and patient adherence to treatment regimens. It involves packaging of drugs in pre-defined doses for the targeted population group and the length of the treatment regimen (SARA, 2005).

Franchising is a transaction enabled by a contract between a health service provider and a franchise organisation. The aim of a franchise is to improve access to quality and price-controlled services (McBride and Ahmed, 2001). Examples of successful franchises include ‘green star’ in Pakistan, ‘ray of hope’ in Ethiopia and Janani in India, Sewa in Nepal and Top Reseau in Madagascar (Patouillard et al., 2007).

Contracting out refers to a purchasing mechanism used to acquire specified services of a defined quality at an agreed price from a specific private provider and for a specific period. This enables the government to purchase services from private providers in order to complement public provision (Marek et al., 1999). Cases of contracting out to private facilities were found in South Africa, Lesotho (Patouillard et al., 2007), Senegal and Madagascar (Marek et al., 1999). However, contracting out has been implemented extensively in Cambodia (Vong et al., 2018).

As for training, it can be either formal or informal, where the private sector is provided with knowledge about treatment guidelines as well as the use of job-aids (Patouillard et al., 2007). Although the training focuses on many issues, the bulk of the training has concentrated on the use of guidelines for integrated management of childhood illnesses (IMCI), the quality of family planning and the treatment of malaria (ibid.).

2.5. Private Sector in Fragile and Conflict-Affected Settings

2.5.1. Background to conflict, fragility and related effects

The focus on conflict and fragility-affected states has gradually increased over the years owing to the critical development challenges posed by such situations (World

Bank, 2018).[9] Among other factors, these challenges are due to high levels of poverty and poor health indicators as well as projections about the exacerbation of the magnitude of such effects. For instance, the OECD report (2016) projected that by the year 2030 the share of extreme poor living in FCAS will rise from 17 per cent to 60 per cent (OECD, 2016). The OECD further indicates that by 2018, 60 per cent of the world's maternal and child deaths were happening in fragile and conflict situations (OECD, 2018). These poor indicators even have the potential to rise and, with diminishing and insufficient aid to such settings (Graves et al., 2015), such contexts may face deeper challenges with regard to the achievement of UHC in particular and SDGs in general.

Defining the terms 'fragility' and 'post-conflict' has been a major area of contention (Witter, 2012, Bertone et al., 2019). To provide a general understanding of the context, some general definitions are provided here.

Within the available literature, the definitions of the term 'fragility' are varied and, to-date, there is no clear definition of the term (Bertone et al., 2019). However, there are three parameters which can be used to measure or define the degree of fragility of a given country. These are 1) limited capacity and willingness of the state to deliver its core functions; 2) legitimacy and effectiveness in the provision of services to fill core functions gaps for the state; and 3) the presence of active conflict/insecurity (Witter, 2012, Bertone et al., 2019, Newbrander, 2006). The interrelations and intersections of these three parameters are well illustrated in a framework provided by Call (2011).

[9] https://www.worldbank.org/en/topic/fragilityconflictviolence/overview

The framework indicates the possibility that a country may exhibit more than one of these characteristics. The parameters alluded to earlier emphasise that the state has a central role regarding the creation of peace as well as the provision of health services. The intersection also highlights the possibility that a 'fragile tag' cannot be limited to countries that are experiencing active conflict.

According to Sweeney (2009), a post-conflict setting refers to a country or area that is either emerging from conflict or one that has experienced a conflict far back in its history. However, other scholars (Collier et al., 2003, Witter, 2012) warn that the period of transition within post-conflict settings is not linear; it takes time and there is a high possibility for some countries to relapse into conflict.

FCAS are heterogeneous and unique in many ways (Pavignani et al., 2013, Bertone et al., 2019, Addison et al., 2001). This heterogeneity or uniqueness derives from characteristics which include distance from conflict, the progressive nature of the conflict, the scope/coverage of the conflict/destruction, and the cause of the destruction/conflict. There can also be variations within categories and/or intersections between these categories as has been detailed below.

a) *Distance from conflict*, where the end of conflict is determined by relative peace created by the cessation of hostilities (Addison et al., 2001): Some countries are in the immediate post-conflict period, while others have experienced conflict far back in their history. For instance, the ReBUILD Consortium categorised some partner countries as being far from conflict (Cambodia 1970-1998; Zimbabwe 1980s) and

others as being relatively close to the immediate post-conflict period (Northern Uganda 1985-mid 2006, Sierra Leone 1991-2002, Witter et al., 2017).

b) *Progression/occurrence of conflict*: The length of the conflict is another area for categorisation of conflict. Conflict may be short-term or long-term although the latter is more common. Pavignani et al. (2013) recognise that for many FCAS, the disruption is chronic and extensive and not merely part of a transient trajectory towards recovery, a situation which other authors have referred to as a cycle of conflict (Witter, 2012). In the available literature, countries that have experienced cycles of conflict include Afghanistan, the Central African Republic (CAR), the Democratic Republic of Congo (DRC), Somalia and Palestine (Pavignani et al., 2013).

c) *Scope of the conflict within the given area*: Some of the conflicts directly affect a given part of the country rather than the whole country. For example, in the Republic of the Congo (Congo-Brazzaville), the oil sector, which is offshore, was largely unaffected by the fighting (Addison et al., 2001). Since 2011, the Northern Nigerian states of Yebe and later Borno and Adamawa have experienced unrest due to attacks by the Boko Haram militant group (Ager et al., 2015). In the case of Northern Uganda, it experienced unrest for 26 years while the rest of Uganda remained largely peaceful (Namakula et al., 2011). Northern Uganda was the study setting and Chapter 3 provides more details about this conflict.

d) *Nature of the conflict and/or fragility*: In contrast to the types of fragility presented in a), b) and c), the fragility in some countries is caused by a mix of factors rather

than a single factor, while in others it is caused by one factor, which may not necessarily be linked to actual fighting. In Haiti, for example, disruption has been caused by numerous factors, including natural disasters and political instability. Fragility in Somalia and Palestine, however, has been a result of political volatility (Pavignani et al., 2013). Zimbabwe, on the other hand, seems to present a unique case unlike all the previous countries, given that the fragility was mainly caused by a protracted economic crisis (Witter et al., 2017). The economic crisis has been attributed to many factors, including the continued intervention by the Zimbabwean government in the DRC and the decline in agricultural production following the seizure of white-owned farms (Addison and Laakso, 2000).

Violence as a result of conflict generally affects the social, political, economic and demographic fabric of the affected settings (Sweeney, 2009). In particular, conflict, among other effects, directly or indirectly leads to death and increases the mortality rate in a given area, causes displacement, affects fertility levels and increases the vulnerability of the population (Guha-Sapir and D'Aoust, 2010).

Pavignani et al. (2013) further note that conflict affects each of the six health system building blocks and provide a detailed write-up about health service delivery, human resources for health, financing, drugs and technology, health information as well as leadership and government (Pavignani et al., 2013). The purpose here was not to detail all the effects but to single out issues that are most relevant to the study.

2.5.2. Health status and service provision in fragile and conflict-affected settings

Depending on the degree of fragility and the phase and length of conflict in each country or area, the effects listed above are experienced differently by different countries. For instance, in relation to healthcare, Pavignani et al. (2013) note that, although there may be some commonalities observed in relation to the health indicators, such as life expectancy and infant mortality, the determinants of the outcomes are frequently context-specific (p. 45).

2.5.3. The private sector in FCAS

The private health sector in many FCAS, including Somalia and Afghanistan, has been thriving (Pavignani et al., 2013) and this takes the form of both humanitarian and private for-profit businesses. The presence and proliferation of the private sector in such settings have been attributed to several factors, including the absence of the public sector, limited state investment in health, absence of the rule of law, hence limited regulation resulting from such a gap, and capital inflows in the case of Somalia. Conflict affects health service provision in two ways. First, conflict leads to the destruction of the functional public health infrastructure (Namakula and Witter, 2014, Downie, 2012). For example, in Somalia, the previously functional public health system was weakened by the civil war which has been going on since 1991. Because of the civil war, the modest health infrastructure that existed before the onset of the war has been destroyed. The few existing health facilities became homes for internally displaced persons (IDPs) and at times armed tribal militias (Downie, 2012). This situation is like that in many conflict-affected areas.

Second, conflict weakens state capacity to invest in health (Sweeney, 2009). This situation results from shrinking revenue, on the one hand, and increasing spending on security, on the other (Buckely et al., 2015, Sweeney, 2009, Pavignani et al., 2013). The state's inability to invest in health affects its capacity to provide health services. This creates a vacuum, which is filled by non-state actors (Pavignani et al., 2013). According to Sweeney (2009), these non-state actors are comprised of NGOs (local and international) and the local private sector (p. 23-35). These actors play varying roles.

NGOs do not only take on the role of funding health but also that of service provision. For instance, in the Republic of South Sudan, which experienced civil war for 40 years, the international donor agencies, including USAID and WHO, are the largest players in the funding and implementation of largely emergency health services (Downie, 2012). The international NGOs (INGOs) often provide services on a parallel basis and with a humanitarian focus so as to address immediate health problems emerging out of the conflict (Namakula et al., 2011, IOM, 2006). In most cases, the services rendered by INGOS are short-term in nature and, therefore, end with the end of conflict, often leaving a vacuum not just in service provision but also in terms of deficiency in capacity and experience (Ssengooba et al., 2017). For example, in Sudan, there was uncertainty when the two US-funded health programmes, the Office of US Foreign Disaster Assistance (OFDA) and the Sudan Health Transformation Project (SHTP), which had been delivering high-impact health services in 200 facilities and 14 countries, respectively, were about to close by the end of 2012 (Downie, 2012).

Sweeney (2009) notes that the local private sector is also active in health service provision in periods of active/violent conflict as well as during the post-conflict period (p.34). The private sector in such settings is mainly characterised by informality and having a predatory nature and are resilient (Sweeney, 2009) and heterogeneous, and provide poor quality services (Buckely et al., 2015, Pavignani et al., 2013).

Sweeney (2009) adds that the nature and extent of the post-conflict private sector is shaped by characteristics specific to post-conflict situations. These include fragility and/or pockets of violence, limited regulation, unclear property rights and unclear channels of conflict resolution. In areas of fragility, the rule of law is limited and so is regulation of providers, hence the increased informality. Pockets of violence may also limit the form that the private sector takes and the kinds of activities that the private sector can engage in (ibid.). According to Pavignani et al. (2013), the demand for services also enables the private sector to thrive in such settings. Inability of the government to pay adequate salaries also results in moonlighting by public sector staff, hence the continuation of a parasitic relationship by the private sector (ibid., p.52).

Examples of local private sector providers include low-level entrepreneurial activities by individuals and small groups (Sweeney, 2009), and pharmaceuticals are also a common category of providers in conflict-affected settings, particularly Somalia and Afghanistan (Pavignani et al., 2013).

In many conflict-affected settings, the for-profit sector has continuously gained popularity and, according to Pavignani et al. (2013), it is thriving. In some contexts, it

is the first (and sometimes only) point of care for advice and also reaches large percentages of populations compared to the public sector (Buckely et al., 2015).

Pavignani (2012) in Buckely et al. (2015) notes:

> Commercialisation of healthcare provision has advanced to such an extent that it has become irreversible. The healthcare business involves many entrepreneurs and workers, and moves large monies, which shield it from public competition, and make it indifferent to technical considerations. (p.3)

This is quite ironical, given that populations in conflict-affected situations are characterised by high levels of poverty (Pavignani 2013), which are also attributed to loss of property and inability to work (Sweeney, 2009) The package of services provided by the private for-profit sector is mainly curative, with a limited focus on preventive services (Pavignani et al., 2013).

In the case of Somalia, despite the high OOP fees paid by patients, services by the private for-profit sector are low-quality and poor value for money (Buckely et al., 2015). This, however, does not deter patients from seeking these services because they are perceived to be better in quality, easily accessible and diverse (Pavignani et al., 2013). For example, in Afghanistan, patients shunned seeking services from contracted-out NGO facilities in preference for those provided by the private for-profit sector (ibid.).

In FCAS, engagement of the local private sector has been presented as one with many benefits (Avis, 2016:2, De Vries and Specker, 2009). These include 1) having an interest in peace-building and stabilisation efforts rather than large enterprises as they suffer more from conflict; 2) having a presence at sub-national level; 3) the potential to provide a stimulus for regional development; and 4) the ability to maintain linkages with other local enterprises.

However, the private for-profit sector in fragile and conflict-affected settings face a myriad of challenges. These include absence of the rule of law, suspicion of the private sector, limited basic services, rent-seeking and weak government with questionable legitimacy (Avis, 2016). Other challenges include excessive business regulation, unpredictable government behaviour, high transaction costs (WorldBank, 2016) and insecurity (Sweeney, 2009). Despite these challenges, the local private sector has demonstrated the capacity to show resilience in the face of shocks by changing form and structure (WorldBank, 2005, Avis, 2016).

In FCAS, regulation of the private sector is important, although it does not come without challenges and the literature has shown some innovations by the providers as well as initiatives by governments. For example, in Somalia, where the government is illegitimate and therefore unable to regulate, the private sector has come up with some innovations, such as using local courts (WorldBank, 2005). In Afghanistan, the Ministry of Health is gradually taking an interest in regulation and stewardship of the private health providers (Cross et al., 2016).

Whereas previous studies have highlighted the challenges faced by private providers, studies that bring out the voices of the providers are limited. Hence, this study sought to understand the challenges as well as the resilience of FPFPs during and after conflict. The study also sought to highlight resilience within each of the FPFPs.

2.6. The Market, Price Mechanism and Demand for Healthcare

2.6.1. Defining a market and price mechanism

According to McPake et al. (2013), the role of the market and competition in healthcare has been brought to prominence by the discussion of healthcare reforms and also the increased recognition of the presence of a large volume of private healthcare activity (p.139)

There is no one single and right definition for the term ‘market’. The meaning of the term depends on the context and the perspective of the person who attempts to define it. Below is a summary of some definitions which were made use of by this study. A market can be defined in three ways; it can refer to a physical place, a set of decisions for price formation, a group of individuals who transact within a boundary or an institution that influences mechanisms for exchange. The definitions are laid out below:

a) *A market as a physical place*: To a layperson, a market is commonly defined as a physical place where people go to buy food or any other products. In some rural areas, a market is the place where small farmers take their produce on any day weekday, as agreed by the residents, to have other people buy the produce.

b) *A market as a set of decisions for price formation*: In mainstream economics, a market is a set of decisions made by consumers and producers of a commodity in order to determine the price of the commodity (Ellis F, 1990). This definition highlights the potential for negotiation in relation to price formation. It does not

matter where these decisions are made; if it is a geographical space, then that space becomes the market of that place.

c) *A market as a group of individuals*: The term ‘market’ has also been used to describe the groups of individuals or organisations that make up the pool of actual and potential customers for their goods and services (pp. 10-11)(Brown and Deloitte & Touche, 1994). These groups fall into one or more of the following categories: geographical, demographic or socio-economic, psychographic, behavioural or sectoral.

d) *A market as an institution*: The new institutional economic perspective relates a market to a set of systems, institutions, procedures and social relations infrastructures (ADB-DFID, 2005) or arrangements (McPake et al., 2013) by which buyers and sellers exchange goods and services. The previous two definitions notwithstanding, the researcher found definition (d) more comprehensive.

These buyers and sellers can have specific characteristics, for example, size, number and behaviour, and this is what McPake et al. (2013) term as the market structure. According to Douma and Schreuders (2002), whenever an exchange takes place, a transaction takes place and leads to the transfer of rights of ownership between the buyer and the seller. The buyer (the person who pays money) thus acquires the right to use/own a given good or service whereas the seller (the person who gives up the service/good for sale) acquires the right to use the money that they receive (Douma and Schreuders, 2002). In healthcare, therefore, when a patient visits a private hospital and buys drugs to treat a particular sickness from a pharmacy, that patient

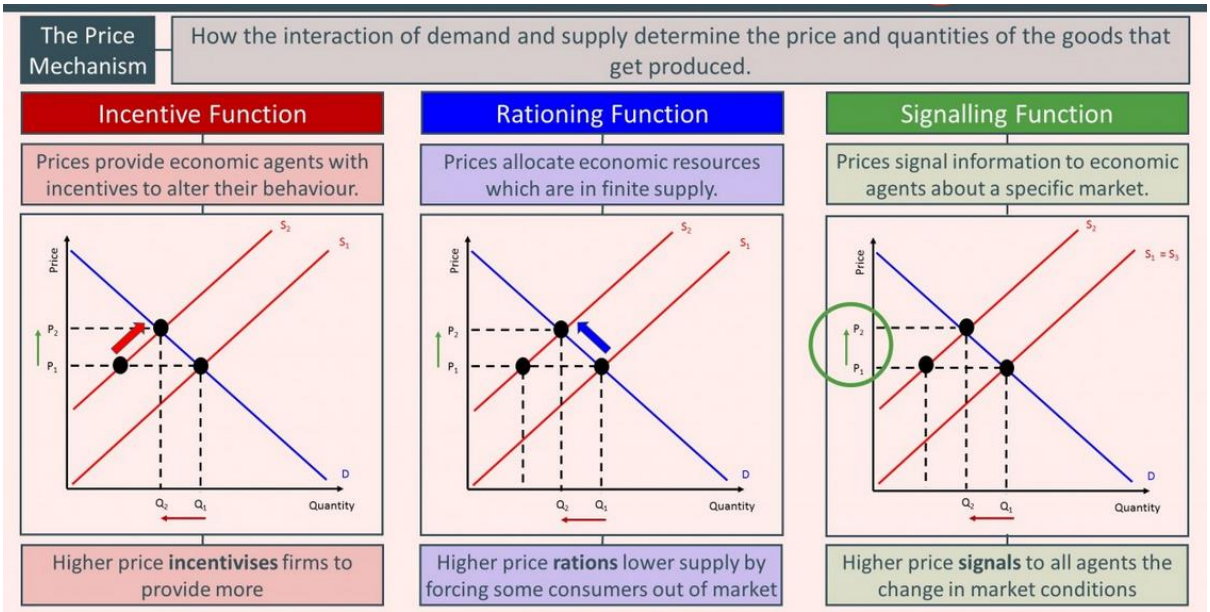
acquires the right to use the medication purchased while the pharmacy owner acquires the right to use the money paid.

The transactions are co-ordinated by the price, which is determined also by the forces of demand and supply (ibid.). This is what is termed as price mechanism. Price mechanism refers to the system where the forces of demand and supply determine the prices of commodities and the changes therein (Harrison et al., 1992). Hence, as indicated by Adam Smith (1776),

> There is an 'invisible hand of price mechanism', in which the hidden hand of the market, operating in a competitive market, through the pursuit of self-interest allocated scarce resources in society's best interest.

The price mechanism has three main functions, namely the allocation/incentive function, the rationing function and the signalling function (Harrison et al., 1992). Through the allocation function, price allocates scarce resources among competing users. Through its rationing function, the price will become high when the demand outstrips supply. The signalling function enables suppliers to adjust to where resources are required and where they are not. For example, if the prices are rising because of high demand from consumers, then this signals to the suppliers to expand their production to meet the higher demand. If there is excess supply in the market, market price will fall so that it helps to eliminate the surplus in the market (ibid.). Figure 5 illustrates the three main functions of price mechanism.

Figure 5: The functions of price mechanism



Source:

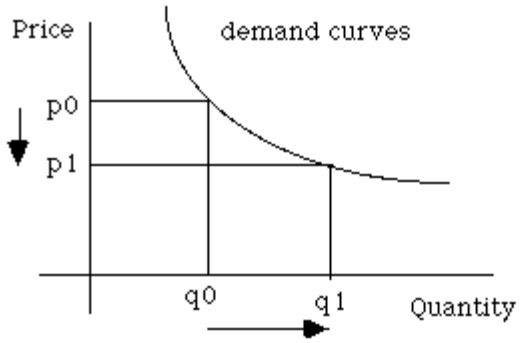
https://ezyeducation.co.uk/images/easyblog_images/1829/b2ap3_large_ThePrice-Mechanism.jpg

2.6.2. Understanding demand

Demand is an important aspect of the markets because it enables us to understand how people make choices and how their choices are likely to change with changing circumstances (McPake et al., 2013). In simple terms, demand refers to the willingness and ability of consumers to buy a product (Whelan and Msefer, 1996). Demand is mostly described as the relationship between price and quality demanded, implying that price is the major determinant of demand (McPake et al., 2013). Hence, the definition of demand then broadens out to refer to 'the quantity of a good or service which a person is willing and able to buy at the given price' (ibid.). This view is illustrated in the simple demand curve. As indicated in Figure 6, the higher the price,

the lower the quantity demanded and the lower the price, the higher the quantity demanded.

Figure 6: The demand curve



Source: Adapted from McPake et al. 2013. p.12

In addition to price, McPake and Normand (2008) and McPake et al. (2013) describe three other factors that determine demand. These include the price of substitute/alternative goods, the price of complementary goods, the income of the buyer, and individual tastes and preferences. All the factors were expressed (McPake and Normand (2008) as

$D= f (P, P_s, P_c, Y, T)$

where D is the demand, P is the price, P_s is the price of substitute goods, P_c is the price of complement goods, Y is income and T is tastes (p.17). However, there are also other determinants of demand, which are less visible but influence our choices and preferences. These include habits, climate and the availability of information (illustrated through advertisement of a product or an effect of a product) (McPake et al., 2013).

However, the health market is unique because it also includes the exchange of the goods that are not co-ordinated by market forces but rather organisations using non-price systems, such as authority. These include consultation time, favours and the provision of information (Douma and Schreuders, 2002, McPake et al., 2013).

2.6.3. Demand for healthcare

McPake and Normand (2008) and McPake et al. (2013) present two main reasons why we should be concerned about the demand for health and healthcare. First, this would help us predict likely reactions and behaviour. Second, knowing something about people's demand for healthcare may tell us something about how much they value health services (p.11).

The demand for healthcare has similarities and differences with the demand for other goods (ibid. p.11 and p13-15). The differences between the demand for healthcare and the demand for other goods are based on a set of four aspects: who chooses and uses the service; the degree of uncertainty; timing; and the degree of enjoyment (see Table 2).

a) *Who chooses and uses the service*: In relation to the demand for other goods/services, the individual makes the choice and uses the service. However, in healthcare, decisions are often made for the individuals because they are either extremely ill or have limited information about their illness. In some cases, the doctor and patient decide (ibid.)

b) *Degree of uncertainty*: Uncertainty is a unique future of the need/demand for healthcare. Uncertainty arises from 1) the fact that the choice of treatment has been made on behalf of the patient who has little knowledge of their illness and the treatment. In this case, there is also uncertainty regarding the treatment outcome; and 2) the inability of individuals to predict when they need healthcare, what healthcare will be needed and how much will be needed. Again, as indicated by McPake et al. (2013), such a scenario constitutes the basis for the need for insurance to cater for unforeseen future health needs. Ultimately, insurance breaks the direct link between the decision to use a service and the price charged.

c) *Timing*: McPake and Normand (2008) and McPake et al. (2013) note that timing between the incidence of illness and ability to pay/source for funds breaks the patterns of incomes determining the demand for services. They note that

> In general, we are healthier when relatively young and relatively rich. These are times when we are least likely to need healthcare but most likely to be able to afford it […] yet, in general, we have medical needs when we are older and usually poorer. (P.11 and p.14)

In such a scenario, insurance as a payment option becomes more relevant, although, as noted earlier, it breaks the direct link between the decision to use a service and the price charged, which is experienced in the demand for other services.

d) *Enjoyment*: McPake and Normand (2008) and McPake et al. (2013) further note that we rarely enjoy using healthcare services, unlike other goods. McPake et al. (2013) describe the experience with healthcare as having long-term gains at the expense of short-term pain or inconvenience.

Table 2: Differences between the demand for healthcare and the demand for other goods

Dimension	Demand for other goods	Demand for healthcare
1. Choice and use of service	The individual makes the choice and uses the service	The individual who makes the choice may not be the same using the service Possibility of joint decision-making between doctor and patient
2. Degree of uncertainty	We are sure of what we need, when and how much	A high degree of uncertainty because of • limited/no advance knowledge about what we need, when we will need it and how much we will need • not being sure about treatment outcomes and results **Note**: Some health interventions, e.g. immunisation and eye tests, are characterised by certainty in relation to timing and content
3. Preferences and ability to pay	Whoever shows a preference for a service can find resources to pay for it	• Some individuals cannot afford to pay and therefore have no effective demand. • Intervention of other parties to pay on behalf of others through insurance, subsidies, and charitable funding. • Insurance breaks the link between the decision to use a service and the price charged.
4. Timing		When we are young and relatively rich, we can pay; but when we are old, we are less likely to afford healthcare. Hence, much as we need healthcare more when we are old, we are less likely to afford it then. Insurance breaks the link between the decision to use the service and the price charged
5. Degree of enjoyment of a service	We are more likely to enjoy what we have bought	We seldom experience enjoyment but enjoy long-term gains at the expense of short-term pain or inconvenience

Source: Adapted from McPake and Normard (2008) and McPake et al. (2013)

Despite the differences indicated in Table 2, there are two main similarities, and they are related to the demand curve and the issue of information asymmetry. First, the demand for healthcare is somehow like the demand for other goods. McPake et al. (2013) note that despite the inefficiency of the markets to determine the allocations resources for healthcare, the behaviour of people seeking health services often reflects normal patterns of demand. For example, people may buy more when prices are low and when income rises. They may also buy less when prices are high and income falls. Hence, this scenario could explain the long queues and waiting times for treatment.

Second, just like the demand for other goods, the demand for healthcare also experiences information asymmetry (ibid.). Information asymmetry means that one party to a transaction has more information than another. For example, a professional may have more knowledge about the good/service while the health professionals are also better informed about the illness than the patients (McPake et al., 2013). They further add that such a scenario may lead the health professionals, as agents, to abuse their role to pursue their profit-seeking motive as a supplier. This is one of the justifications for the presence of institutions such as medical ethics and self-regulatory bodies (ibid. p.48).

2.7. New Institutional Economics (NIE) Theory and Its Application

This study utilised the New Institutional Economics (NIE) as the theoretical framework to guide discussion of the findings. NIE has its roots in Ronald Coase's classics, *The Nature of the Firm*(1937) and *The Problem of Social Cost* (1960). However, the term 'NIE' was coined by Oliver Williamson (1981).

Proponents of NIE argue that exchanges/ transactions may not only be explained and controlled by market forces of demand and supply/price mechanism[10], as has been described earlier in section 2.61. Instead, NIE argues that exchanges/transactions can also be coordinated by organisations which mainly rely on non-price systems, such as authority and institutions, in the form of formal and informal rules and norms and networks (Eggertsson, 2013, Douma and Schreuders, 2002, McPake et al., 2013, Williamson, 1981). This implies that relational aspects of organisations are useful in understanding how healthcare markets thrive and sustain exchanges/transactions. NIE introduces contracts as another way of governing transactions, beyond prices.

The main limitation of NIE is that it assumes opportunism within contracts, implying that organisations will take advantage of the situation satisfy their selfish interests (McPake et al., 2013) but this is not always the case. For instance, Dequech (2005) notes that ‘sometimes there is uncertainty among organisations about the reaction of those they relate with, sometimes trust is important in the long run'.

This uncertainty is mainly attributed to bounded rationality (McPake and Normand, 2008, McPake et al., 2013). Bounded rationality, as coined by Herbert Simon (1957), implies that human beings cannot make rational decisions. This is because of three limitations: limited knowledge about all possible circumstances that could affect a situation; limited cognitive ability; and limited time to decide.

[10]This is the basic assumption of neoclassical economics

Therefore, McPake and Normand (2008) conclude that the presence of bounded rationality implies that contracts are incomplete – they cannot specify all relevant possibilities that affect the contracting parties' returns from participating in the contract (p.133). Therefore, they recommend that both optimism and bounded rationality need to be balanced to avoid contractual difficulties (ibid.).

Another concept introduced by NIE is the issue of information asymmetry, which also leads to uncertainty, a key challenge to the demand for healthcare, which has already been discussed in section 2.63. Information asymmetry refers to a situation where one party to the transaction has more information than the other party has.

Although NIE presents a number of concepts, analysis focused on the following ones: 'small numbers' markets, sunk costs (SC), trust as an alternative to price in the market, information asymmetry, credible commitment (CC), relational contracts, institutional coordination and networks as organisational forms/structures. The researcher revisited some of these concepts in Chapter 9.

Application of NIE to the study

The application of NIE to the study is best indicated by showing the linkage between the research questions, analytical insights per objective and the selected NIE parameters that were used for analytical explanations. Research question 1(a) sought to understand the characteristics and evolution of the selected FPFPs during and after conflict. This objective emphasizes security as a contextual factor that makes the market unfavourable, making start-up difficult and affecting the growth and survival of FPFPs in several ways. The analytical focus of this research question was

the opening and closure, growth and survival as well as the opportunities available to and the challenges facing FPFPs during and after the conflict. The NIE concept of sunk costs can enhance our understanding of how much money or resources are invested at the start of a business while credible commitment can explain why, in spite of the various challenges in their life span, the FPFPs survived, or chose not to close up shop or take the business to other areas in the country. Over time, sunk costs lead to credible commitment and, in the long-term, result in contractual relations between FPFPs and other organisations. Additionally, the NIE concept of contractual relations was applied to understand alliances and bonds that are created between FPFPs and other organisations during and after the conflict. The study sought to understand the extent to which these contractual relations (alliances) evolved from spot to long-term contracts, and the challenges as well as opportunities that these created for FPFPs in the conflict and post-conflict period.

Research question 2 (b) sought to understand the market dynamics for FPFPs in post-conflict Northern Uganda. For this research question, the analytical insights the researcher looked out for included the negotiation of markets by FPFPs; challenges and opportunities; adaptation within the FPFP in response to external controls; and the effects of security on the market. The literature had already indicated the conflict-related effects and that there were few providers in the health system. The NIE-related concept of ‘small numbers’ markets can enhance our understanding of the market dynamics for FPFPs in volatile contexts such as Northern Uganda. In such settings, different market dynamics may be of a relational nature (Williamson 1991) as opposed to free competition and exit, which is emphasised by neo-classical economics. For instance, as opposed to staging vigorous competition and creating

‘exit options’ for other providers, some providers may instead decide to support the existing providers to support the health system during the hard times. Such support may create room for contractual relations. The study shed light on the evolution of the contractual relations mentioned above, with specific focus on whether, how and why these changed from spot contacts to long-term relational contracts.

Networks and relationships were also a sub-component to look out for in relation to research questions 2(d) and 3(b). Social network analysis was used to illustrate these networks and relationships, and this is elaborated in the methodology chapter. Analysis focused on linkages and/or the nature of networks (formal or informal) for the coordination of transactions for healthcare as well as the resources exchanged because of the networks. Using the NIE concept of organisational forms, the study sought to understand the effects of these networks and relationships on the organisational structure of the FPFPs and other internal adaptations. According to NIE, there may be various organisational forms in the market because of interactions. One of these is the hybrid form (Williamson, 1981, McPake et al., 2013), which enables the firm to create efficiency and reduce its transactional costs by ensuring coordination between organisations. Other forms include the vertical integrations, where a firm of a different level merges with one at a different level (Douma and Schreuders, 2002, McPake et al., 2013). These forms of structures enable the organisation to reduce the transactional costs (McPake et al., 2013).

CHAPTER 3: UGANDA AND NORTHERN UGANDA – A CONTEXTUAL BACKGROUND

3.0. INTRODUCTION

This chapter is contextual and specific to Uganda and Northern Uganda. The first section presents the broader effects of neo-liberalism and/or SAPs on health service delivery in Uganda. The main argument here is that neo-liberalism affected the health sector and created inequalities while favouring the private sector often at the expense of the public sector. The second section presents actors within the healthcare market in Uganda as well as their roles; it indicates their positions and roles using the Elliot framework and the interaction of these roles. The third section describes the structure of healthcare provision in Uganda within the decentralised contexts, noting the coverage gaps left by the public sector facilities. The fourth section presents the context of Northern Uganda, indicating the effects of conflict on the health system and the actors within the healthcare markets in the region. Lastly are two brief sections, one about public-private partnership (PPP) and the other on regulation.

3.1. Neo-Liberalism and Healthcare in Uganda

The World Bank's diagnosis noted in Chapter 2 – regarding inefficiencies and ineffectiveness in the health sector – seemed true of Uganda, whose health system was dilapidated as a result of economic decline due to civil and military unrest that persisted for more than two decades, from 1962 to 1986 (Macrae et al., 1996). Since

1987[11], the Ugandan government has undertaken seven major structural adjustment reform processes. These are comprised of two major parts: (i) The Economic Recovery and Structural Adjustment Programme of the World Bank/IMF; and (ii) the Sectoral Lending Operations of the World Bank (Makhoka, 2001)10).These reforms were operationalised through the privatization of former state-owned enterprises (SOEs), the enforcement of public sector management controls through cuts in expenditure for basic sectors, particularly education and health, as well as the liberalization of agricultural production and food security (ibid.). Within the health sector, reforms such as the introduction of user fees, decentralisation and insurance were implemented (Ssali, 2018).

There is a consensus in the literature that neo-liberal reforms had only a modest positive effect on the majority of citizens in developing countries (Mavroudeas and Papadatos., 2005, Kentikelenis, 2017, Thomson et al., 2017, Wiegratz et al., 2018). According to the SAPRI report, the SAPs widened the income inequalities in Uganda. In relation to the health sector, the increase in health investment by the government and the related increase in health workers' salaries did not create a significant positive change (Makhoka, 2001). The health workers in public facilities were found to also charge 'illegal' fees to boost their incomes as a response to their inadequate salaries (McPake et al., 1999). The introduction of cost-sharing also largely worked to the detriment of the poor and worsened their access as well as utilisation of public-provided health services (Makhoka, 2001). More patients reported a higher likelihood to select a private or non-governmental facility in seeking medical care (ibid.). The

[11] Structural Adjustment Progammes (SAPs) were first introduced in Uganda in 1981 but failed to take off. They were re-introduced in 1987 under the present National Resistance Movement (NRM) government. Active implementation, however, took effect from 1992 (Makhoka, 2001: 10),

WHO notes that by 2009, spending within the private health sector accounted for more than 70 per cent of total expenditures on health (WHO, 2010a).

To the World Bank, these were indicators of the population's willingness to pay for healthcare services, paving the way for the privatization of health services in the context of several other neo-liberal reforms in Uganda (Ssali, 2018). However, Ssali notes that this was merely a response to the deterioration of the public health system that later became the norm (ibid.: 180).

In their critique of the implementation of neo-liberal reforms in Uganda (Wiegratz et al., 2018), some scholars have concluded that the dynamic interplay of the imperfect market favoured a few players, who became winners, while the majority who were sidelined became losers (Asiimwe, 2018 and Ssali 2018 in Wiegratz et al., 2018). Ssali (2018) expresses equity concerns arising from a market-led health system in Uganda and underscores the need for the state to lead in healthcare provision.

> The vast majority are stuck with poor quality or can only access healthcare from private facilities by engaging in catastrophic expenditures. […] if equity concerns are to be achieved, the state and not the market needs to be responsible for the citizens' health. (p.196)

Apart from user fees, decentralisation was one of the reforms implemented to reduce the role of the state in health service provision in Uganda. Under decentralisation, the power of management of health services was devolved to the districts through the creation of the district health sub-district (HSD)(Asiimwe and Nakanyike, 2007, MOH, 1998). This meant that the district health offices were responsible for overall leadership, strategic planning, supervision, monitoring and coordination of district health services (Tashobya et al., 2018). The Ministry of Health (MOH), on the other

hand, mainly retained the role of developing and distributing policies and guidelines (MOH, 1998).

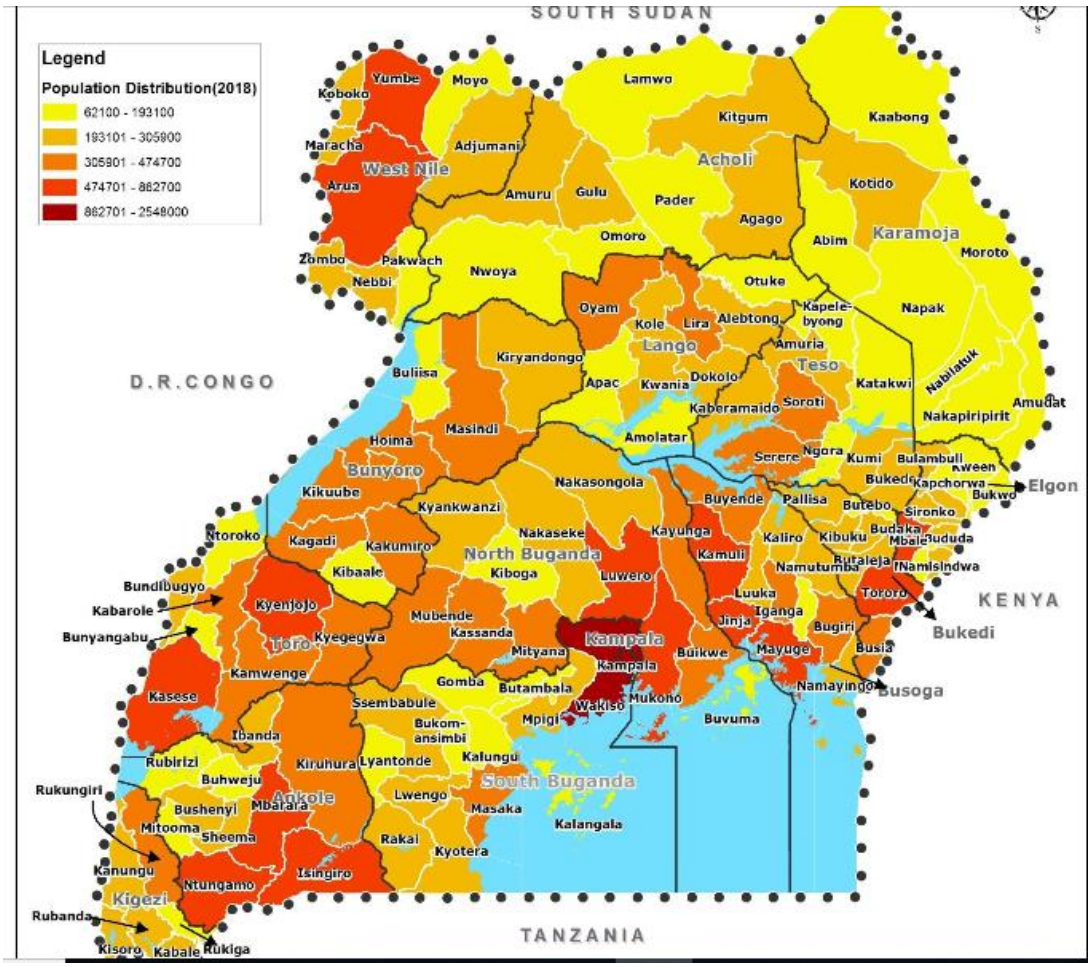
Notably, the fiscal space to carry on the mandate was limited in proportion compared to the mandate transferred (Kiwanuka, 2013). As such, the districts argued for the introduction of user fees as a means of generating revenue and also as a basis for negotiating for the Community Health AIDS Project (CHAP)(Okuonzi and Macrae, 1995). The rapid adoption of user fees by all districts – 42 out of 45 by the year 1999 (MOH, 1999) – implies that districts prioritized their revenue needs with little regard for people's ability to pay (Ssali, 2018).

According to the Uganda Bureau of Statistics (UBOS) Statistical Abstract for 2018, Uganda was administratively divided into 122 districts as of 1 July 2017 (see Figure 7) (UBOS, 2018), having started at 45 in 1998, as noted earlier. Evidence within documents indicating the disbursement of funds to local governments cast a dark shadow over the hopes for expanding the fiscal space and highlight the need for districts to continue generating revenue. For example, as indicated in the Sector Grant and Allocation Guidelines for the year 2017/18, resource mobilisation and allocation is still part of the broader planning and implementation function for the district health office (MOH, 2017). Furthermore, the conditional grant agreement between MOH and local governments for the financial year 2018/19, section 14-part d), page 11 indicated that:

> Local governments shall demonstrate their support on local revenue enhancements so as to improve revenue collection to meet the many recurrent expenditures. (Government of Uganda, 2018)

The health budget allocation for the financial year 2019 increased only by UGX 0.3 trillion from UGX 2.3 trillion in 2018 (Delloitte, 2019).

Figure 7: Map showing districts of Uganda and their populations in 2018



Source: UBOS Statistical Abstract 2018

3.2. Health Service Delivery in Uganda

In Uganda, both the public and private sectors contribute an almost equal half to the provision of health services in almost equal proportions (MOH, 2010a). Notably, the public sector, which is under the direct stewardship of the government and the MOH, dominates in terms of ownership of health facilities countrywide, as was shown for

the Acholi region in Table 3. The structure of the public health system of Uganda has been presented in varying ways in the available literature to serve the purposes of researchers (MOH. et al., 2012, Tashobya et al., 2018). However, in this thesis, we refer to the structure as presented in government policy, specifically the Uganda Health Sector Strategic Investment Plan (HSSIP) 2010/11– 2014/15 (MOH, 2010a). Typically, the health system components referred to include the facilities, the services provided, the population covered and, in most cases, the administrative unit which is part of the decentralised structure for the management of health service delivery in Uganda.

The public health system is structured in a tiered ascending spiral of infrastructure, where the complexity of services provided as well as the population served increases by ascending level of facility (MOH, 1998, MOH, 2012, MOH. et al., 2012). Under the decentralised system, the health facilities are also attached to the relevant level of administration. For example, the health centre I, the lowest health facility, mainly focuses on preventive services through the provision of community outreach at the village level (the smallest administrative unit[12]). On the other hand, HC IVs, or the district general hospital, acts as the highest level within the district and as the health sub-district health centres. The health sub-district facility is supposed to have a coverage area of approximately 100,000 people (MOH, 1998) and the capacity to provide a minimum package of services (MOH, 2008) provided for in the Health Sector Investment Plan (HSSP). These include emergency surgical and obstetric

[12] Although the village is perceived to be the smallest administrative unit, in most cases the volunteers are overwhelmed by the coverage area. Some villages, for example, may have over 1,000 households, so that they have to be divided into A and B.

services (MOH, 2010a). Above this level are regional referral hospitals, and above these, the national referral hospitals, which are the highest level (MOH. et al., 2012).

The structure of the public health system, as shown in Table 3, was meant to fulfil two objectives, which are indicated on page 12 of the first National Health Policy: 1) strengthening the referral system; and 2) creating more linkages between the district level and the centre as well as between the public and the private sector (MOH., 1999). Essentially, the assumption behind this structure was that referrals naturally occur from the lower level to the higher level. However, this is not usually the case, as clients often tend to bypass the facilities that are within the vicinity of their homes (MOH. et al., 2012). The factors to which this situation is attributed include shortages of human resources for health and a lack of equipment and supplies, which compromise the quality of care in some public facilities (Parkhurst and Ssengooba, 2009). Other factors include disrespect and abuse by health workers (Kyomuhendo, 2003) as well as informal and illegal payments within the public sector, particularly in relation to maternal deliveries (McPake et al., 1999, Birungi et al., 2001, Nabukeera, 2016). In such cases, the private sector becomes a substitute for the private sector(Konde- Lule et al., 2010).

Table 3: Levels of the public health system, location and services provided

	Level of health facility	Corresponding administrative level (within decentralised system)	Roles/package of services	National health facility standard	Current situation
7	National referral hospital (NRH)	National	All services by the RHH and general hospitals plus comprehensive specialist services, research and teaching	1:10,000,000	1:30,0000
6	Regional referral hospital (RRH)	Region	All services of general hospitals plus teaching and research	1:3,000,000	1:2,307,692
5	District/General hospital	District	All HCIV services plus in-service training, consultation, research and community-based healthcare programmes	1: 500,000	1:263,157
4	Health centre IV (HC IV)	County as sub-district or constituency	All HCIII services plus preventive, promotive, outpatient, curative and inpatient services, emergency surgery and blood transfusions	1: 100,000	1:187,500
3	Health centre III (HC III)	Sub-county	All HCII services plus, preventive, promotive, maternity and inpatient services. Delivery services may be available	1:20,000	1:84,507
2	Health centre II (HC II)	Parish	Preventive, promotive and curative services (mainly Out-Patient). Antenatal services may also be available	1:50,000	1:14,940
1	(Village health team/VHT) HC I	Village	Community-based healthcare services, health promotion and education (to service approximately 100 people using the community	1:1000,1per 25 households	

Sources: Uganda NHA Report 1998/99-2000-01; Health Sector Strategic Plan and Ministry of Health Inventory 2002; MOH HMIS 2009; MOH Statistical Abstract 2010; Uganda Health Sector Strategic Investment Plan 2010/11-2014/15

The health system in Gulu follows a hierarchical structure like that at national level, except that there is no regional or national hospital. The levels of care under the public sector include health centres I, II, III, IV and a hospital. Facilities are under the jurisdiction of the army, the municipality, private not-for-profit providers (PNFPs) (mission sector) and private for-profit providers (PFPs) as well as NGOs. More details about the health system in Gulu are presented in Chapter 4.

3.3. Private Health Sector in Uganda

Private health service providers comprise private not-for-profit organisations (PNFPs); private for-profit healthcare providers (PFPs), which are divided between formal and informal, also known as commercial healthcare providers; and traditional healers and complementary medicine practitioners (TCMPs)(MOH, 2012, Konde-lule et al., 2006).

The PNFPs sub-sector comprise both facility-based and non-facility-based organisations. As shown in Table 3, the majority of the facility-based PNFPs are religious-based and fall under three umbrella organisations: the Uganda Catholic Medical Bureau (UCMB), the Uganda Protestant Medical Bureau (UPMB) and the Uganda Muslim Medical Bureau (UMMB) (MOH, 2002 in (Konde-lule et al., 2006). UCMB and UPMB own more facilities (37% and 31% respectively), with the other two bureaus having relatively few facilities countrywide (MOH, 2010a).

By 2002, UCMB and UPMB together owned 78 per cent of the 490 PNFP health units in the country, while the rest fell under other humanitarian organisations and community-based healthcare organisations (Konde-lule et al., 2006). According to

Tumwesigye (2013), any surplus in PNFPs is reinvested and used to improve the quality, scope and volume of services or to expand the infrastructure required for services. However, as earlier indicated in Chapter 2, the extent to which this claim is true is debatable.

3.3.1 The private for-profit healthcare providers (PFPs)

The MOH defines the PFPs as 'the other sector' that encompasses all cadres of health providers in the clinical, dental, diagnostics, medical, midwifery, nursing, pharmacy and public health categories who provide private health services outside the public, PNFP and the traditional and complementary medicine establishments (MOH, 2002). According to Konde-lule et al. (2006), the definition provided above only caters for the formal sector. Furthermore, the definition only focuses on the cadres who work within the facilities rather than the facilities themselves, although to the layperson, the name for-profit providers does not refer to the facility. Over the years, surveys about PFPs have been limited. Odedo (2001) in Konde-lule et al. (2006) conducted a study of PFPs in Uganda. He broadly classified FPFPs into medical clinics, dental clinics, drug shops and maternity homes, with drug shops accounting for the largest proportion of all the facilities.

3.3.2 The informal for-profit providers

According to Omaswa (2006), informal providers (IPs) in Uganda include drug sellers in the confinements of shops and clinics and also drug vendors and unregistered pharmacists.

3.3.3 Traditional or complementary practitioners (TCMPs)

According to the WHO traditional medicine strategy, traditional, complementary, and alternative medicine (TCAM) refers to a set of healthcare practices (indigenous or imported) that are delivered outside of the mainstream healthcare system. In the African setting, it may encompass indigenous healthcare practices such as bone setting (traditional bone setting), as well as imported complementary and alternative medicine products and practices, e.g. acupuncture or chiropractic as well as local herbal medicines or products (WHO, 2014). In Uganda, the common types of Traditional Complementary Practitioners(TCPs) include traditional birth attendants, bonesetters, herbalists and traditional healers (Omaswa, 2006). A traditional healer is one who is recognized by his community as a healer, and uses indigenous knowledge handed down from generation to generation, to alleviate diverse forms of human suffering (ibid.). The main traditional healing practices described include spiritualism, herbalism and 'false teeth' extraction. Although witchcraft is mentioned among the practices, all healers tend to dissociate themselves from this practice (Konde-lule et al., 2006). Among other forms of illness, traditional healers have been visited mostly in cases of mental illness because of the belief that mental illness is caused by an attack by an evil spirit, witchcraft or curses (Ovuga et al., 1999, Akol et al., 2018).

There also exist the non-indigenous traditional or complementary practitioners (TCMPs), such as practitioners of Chinese and Ayurvedic medicine, although these are relatively new and have no formal linkages with the public and private providers (MOH, 2010a).

Table 4: Categorization of the private sector in Uganda

	Categories	Sub-categories
1	Profit orientation	Two extremes: – For-profit – Not-for-profit
2	Ownership	– Mission-owned – Individual-owned
3	Infrastructure	– Facility-based –Non-facility-based
4	Formalization/ Licence	– Formal private for-profit providers (with licence) –Informal private for-profit providers (without licence)

Source: Author analysis

3.4. Partnership with the Private Sector in Uganda

According to the second National Health Policy, the Government of Uganda recognises the private sector as a major stakeholder and partner in the provision of health service delivery across the country (MOH, 2010b) and also as a partner in the provision of the national minimum healthcare package (MOH, 2008). The government also encourages public-private sector partnerships (PPPs) in the implementation of the National Development Plan (NDP) as well as other sector plans, including health(MOH, 2010a).

Nevertheless, for over 40 years, government partnerships in health have been dominated by engagement with the mission/PNFP sub-sector sector, particularly through their bureaus (MOH, 2010b, MOH, 2010a, MOH, 2012) while leaving out the for-profit sector. To this extent, the mission sector has been given subsidies for

primary healthcare and drugs as well as staff for purposes of expanding and achieving UHC. Furthermore, the mission sector has been invited to various committees in the MOH management structure and also allowed to participate in the discussions (Ssennyonjo et al., 2018).They have also been co-opted to take part in the accreditation of facilities which qualify to remain open. The government- PNFP (mission sector) relationship has also been characterised by challenges such as mistrust and rent-seeking by political leaders. However, various coping strategies were developed to ensure sustainability of the relationship for broader health sector gains (ibid.). With the recent development in scaling up strategic purchasing (results-based financing), the mission sector facilities have also been able to benefit more compared to their for-profit colleagues, even in post-conflict settings (Witter et al., 2019). Apart from regulation, these engagements and relationships have been quite limited in relation to the private for-profit sector. The study sought to explore if there are any relationships, or even partnerships, between the FPFP facilities and the government.

The next section presents a brief discussion on the regulatory relationship between the public and private not-for-profit sector as well as related challenges.

3.5. Regulation of the Private Sector in Uganda and Related Challenges

Regulation refers to interventions initiated by the government to correct market failures (Muthaka et al., 2004, Ensor and Weinzeirl, 2006). Although this definition of regulation stresses the importance of the leadership of government in regulation, regulation activities may be devolved to other actors and bodies such as professional bodies as well as other agencies (Ensor and Weinzeirl 2006). In Uganda, the

operating licenses for the FPFPs are provided by the various related professional medical associations such as the Uganda Medical and Dental Practitioners Council, the National Drug Authority (NDA) and Allied Health Professionals (AHP). Hence, it is not surprising to find lists of FPFPs in the records of each of the professional associations. These lists are supposed to be updated annually based on payment for a licence.

Over time, the Government of Uganda has made several deliberate policies to encourage the continued growth and contribution of the private sector to national development (The Republic of Uganda, 2010a). Among these is the easing of tariff barriers, although non-tariff barriers still constrain overall trade freedom. Although such policies have mainly encouraged the participation and growth of the formal private sector in health service delivery, they have not been able to tame the proliferation of the informal private sector (Konde-Lule et al., 2006). A similar problem has also been identified in other LMICs such as Kenya (Government of Kenya, 2002).

Yet, given that the level and quality of services obtainable from the private healthcare providers are as varied as the providers themselves are, regulation of activities of these providers is important in order to safeguard patients and create order (Muthaka et al., 2004). Some scholars have identified the increasing numbers as well as proliferation of the private sector actors as a basis for regulation to create some order (Konde-Lule et al., 2006; Doherty, 2011; Doherty 2013). Within the UHC umbrella, the private sector needs to be regulated to ensure financial protection of the populations (McPake and Hanson, 2016).

In many LMICs, such as Uganda and Kenya, the success in regulating the private sector has been hindered by factors that include high costs, lack of information about those being regulated, poor legal infrastructures, and lack of clarity/agreement on what aspects to regulate (Muthaka et al., 2004, Ensor and Weinzeirl, 2006, Kondelule et al., 2006).

3.6. Contextual Background of Northern Uganda

From 1986 to mid-2006[13], Northern Uganda experienced violent armed conflict, in particular the war between the government and the Lord's Resistance Army (LRA) (ARC, 2007, Kindi, 2010, Namakula and Witter, 2014, Namakula et al., 2011, MOFPED, 2002). The effects of the war have been widely documented: loss of lives, physical injuries; displacement of populations; destruction of livelihoods and the resultant poverty; suspension or dysfunctionality of public/government provision; and increased presence of other actors, including INGOs (Rowley et al., 2006, World Vision., 2009, Kindi, 2010, UKPCDP, 2013). Increased susceptibility to illnesses resulted from congestion in camps (ARC, 2007), the flight of health workers and other human resource challenges (Brown, 2006, Namakula and Witter, 2014, Roberts et al., 2009). All these effects elucidate the fragility created by the war in the Northern Region.

In June 2006, relative peace[14] was ushered into Northern Uganda following a cessation of hostilities agreement signed between the government and the LRA

[13] The conflict period runs from 1986 to mid-2006. The post-conflict period runs from mid-2006 to date.

[14] I refer to 'relative peace' here because the rebel leaders refused to sign the final peace agreement but signed only the ceasefire agreement (see ARC, 2007; Kindi, 2010). Hence, it is

rebels (Kindi, 2010, ARC, 2007), hence creating prospects for the recovery and development of the region. The displaced population in camps was dissolved into a number of unplanned satellite/transit camps; more than 85 per cent of IDPs living in camps either moved to transit/satellite camps closer to their homes, returned to their villages of origin, or 'commuted' between their homes and the camps (IDMC, 2008, Brück and Bozzoli, 2008). During the post-conflict period, the movement of populations from camps to their original villages have raised issues of access and equity as well as the need for health system reconstruction (Namakula and Witter, 2014). The effects of the conflict were so profound that the region lags behind the rest of the country, with poor human development indicators, as will be explained in section 3.7.

3.7. Socio-economic and health indicators for Northern Uganda

The Uganda National and Household Survey 2016/7 indicated that the literacy levels in Northern Uganda have remained relatively high; however, there exist sub-regional differences. The literacy level in the Acholi sub-region is still below the national average (UBOS, 2016a). For instance, data shows that in the financial year 2012/13, the literacy level in Lango was 71.4 per cent while that in the Acholi sub-region was 67.7 per cent. In the financial year 2016/17, the literacy level in Lango improved to 77.6 per cent while the Acholi sub-region registered a decline to 59.7 per cent. Over the years, the Ministry of Gender and Social Development (MoGSD), with support from other partners, has implemented the functional adult literacy (FAL) programme

not clear whether the rebels will come back to terrorise the region or not. Nevertheless, the region has prospects for recovery and development. Various investments have been made under the framework of the Peace, Recovery and Development Plan (PRDP). See Government of Uganda (2007, 2012)

which links literacy to livelihood and other needs.[15] Nevertheless, even with this safety net, the literacy level in Acholi only increased to 61 per cent. This is still lower than the national average of 73.5 per cent (ibid.)

In 2016, the total fertility rate in Uganda – interpreted as the number of children that a woman can have during her child-bearing age – was 5.4 children (UBOS, 2016b). Whereas the total fertility rate of Northern Uganda was not indicated, there is evidence that the population of Northern Uganda is quite high and this can be illustrated using household size (UBOS, 2016a). According to the Uganda National Household Survey (UNHS) report for 2016/17, the household size of the Northern Uganda sub-regions was high (Acholi 5.5, Lango 5.1) compared to the national average household size of 4.7 people (UBOS, 2016a).

Results from the UNHS indicated that the proportion of the population living in poverty in Uganda increased from 19.7 per cent in 2012/13 to 21 per cent in 2016/17, an equivalent of about 10 million people in Uganda are living below the poverty line. (UBOS, 2016a). Interestingly, the Northern region[16], which had consistently been the poorest region in the country in the last decade (Appleton et al., 1999, Brück and Bozzoli, 2008) registered a decline in poverty from about 44 per cent in 2012/13 to 33 per cent in 2016/17(UBOS, 2016a). Despite this performance, the poverty levels in the Northern Region are still higher than the national average. Table 5 summarises the trends in poverty for the Northern Region and the national average from 1992-2016.

[15] https://uil.unesco.org/case-study/effective-practices-database-litbase-0/functional-adult-literacy-fal-programme-uganda

[16] Comprising Acholi and Lango sub-regions as per UBOS glossary for UNHS 2016

Table 5: Poverty trends in Uganda by region, 1992-2016

Year	Region				
	Central	**Eastern**	**Northern**	**Western**	**National average**
1992			74		56
1993	45.6	58.8	73.5	52.7	
2000	19.7	34.9	63.7	26.2	
2003	22.3	46.0	63.0	32.9	
2006	16.4	35.9	60.7	20.5	
2010	10.7	24.3	46.2	21.8	
2013	4.7	24.5	43.7	8.7	19
2016			33		21

Sources: UNHS 1993, 2013; UNHS, 2016; (World Bank, 2016)

A poverty proxy survey conducted in 2013 by the ReBUILD Consortium in four sub-counties in four villages in Gulu district, two of which are part of Gulu municipality, had earlier revealed that poverty levels were still relatively high in the district and even higher among female-headed households (Ssali et al., 2011, Ssali et al., 2016).

The major symptoms of ill health and injury for Northern Uganda, as indicated in the UDHS, were malaria, respiratory infections, severe headache, general body weakness, abdominal pain, chills, childbirth-related, mental disorders and others (UBOS, 2016a). In the Acholi sub-region, the incidence of malaria was high (30.6%) followed by respiratory infections (13.3%) (ibid.).

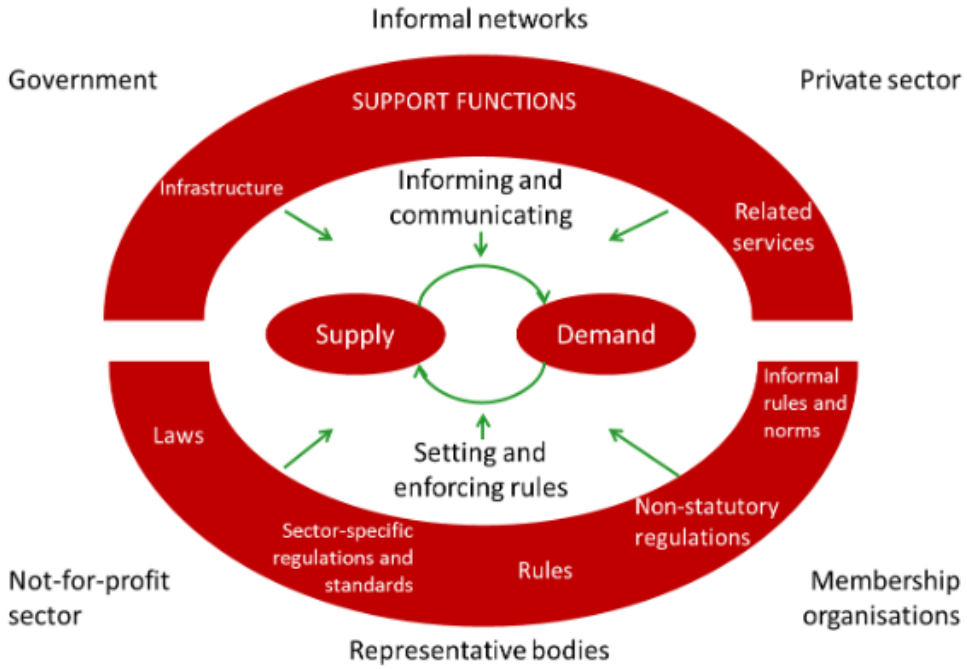
Despite the high poverty levels, the UNHS (2016/17) indicates that a high number of people in Northern Uganda (Lango 55%, Acholi 35%) sought treatment from a private hospital or clinic, while 6.4 per cent and 7.2 per cent of the population in Lango and

Acholi sub-regions, respectively, sought care from pharmacies. Those who sought care from a public health centre were 31 per cent and 53.4 per cent for Lango and Acholi sub-regions, respectively. Fewer people in the two sub-regions (3.9% and 4.6% respectively), however, visited government hospitals (UBOS, 2016a)

3.8. The Healthcare Market in Northern Uganda

The players in the healthcare market in Northern Uganda are similar to those in the whole country (MOH, 2010a, MOH. et al., 2012) and resemble those indicated in Elliot et al. (2008) framework (Figure 8), which is indicated in Bloom et al. (2014).

Figure 8: Framework for understanding the roles of actors in a pluralistic health system



Source: Adapted from Elliot et al. (2008)

Elliot's framework helps us understand the pluralistic and complex nature of the health system. At the centre of the framework are the forces of demand and supply

which co-ordinate the market. However, many players also exist within the same setting. The framework highlights the importance of interaction between players through formal and informal networks. The role of the state to regulate the market through formal laws is also highlighted as part of the major features (Bloom et al., 2014).The supply side comprises public, PNFP and PFP sectors. Table 6 shows that the public sector leads in ownership of health facilities, followed by the Uganda Catholic Medical Bureau (UCMB), and then the Uganda Protestant Medical Bureau (UPMB). There were no facilities owned by the Uganda Muslim Medical Bureau (UMMB). One facility appeared in the 'other specify' column but this was not explained in the report (AVSI., 2011).

Table 6: Summary of health facilities per district in Acholi sub-region based on ownership by government and religious bureaus[17]

District	Level of health facility	Ownership					
		Government	The Catholic Diocese	The Anglican/ Protestant Diocese	The Uganda Muslim Supreme Council	Others, specify	Total of HC
Kitgum	HC II	9	0	2	0	0	11
	HC III	8	0	0	0	0	8
	HC IV	1	0	0	0	0	1
	Hospital	1	1	0	0	0	2
Gulu	HC II	29	2	1	0	1	33
	HC III	14	1	0	0	0	15
	HC IV	2	0	0	0	0	2
	Hospital	1	1	0	0	0	2
	Regional referral	1	0	0	0	0	1
Pader	HC II	15	2	0	0	0	17
	HC III	7	0	0	0	1	8
	HC IV	2	0	0	0	0	2
Lamwo	HC II	11	0	0	0	0	11
	HC III	6	1	0	0	0	7
	HC IV	2	0	0	0	0	2
Amuru	HC II	11	0	3	0	0	14
	HC III	3	2	0	0	0	5
	HC IV	1	0	0	0	0	1
Agago	HC II	24	0	0	0	0	24
	HC III	8	0	0	0	0	8
	Hospital	0	1	0	0	0	1
Nwoya	HC II	7	1	3	0	1	12
	HC III	3	0	0	0	0	3
	Hospital	1	0	0	0	0	1

Source: Comprehensive health facility assessment for Acholi sub-region (AVSI., 2011)

[17] This picture has largely changed, given the efforts of rehabilitation of government/public facilities during recovery. Nevertheless, their optimal functionality is yet to be achieved

Although PFPs also operated within the same setting, little has been documented about them. Yet, as Bloom et.al (2011) point out, ‘markets are frequently segmented, with actors that serve different social groups following different rules and behavioural norms’; they also vary widely in terms of their practice, type of knowledge and associated training, the extent of public subsidy and relationship with the legal system (p.i48). Other players in the healthcare market in northern Uganda include NGOs and donor agencies, which mainly fund and actively engage in the implementation of health services and vertical health programmes (Namakula et al., 2011).

On the demand side are the public who demand/use health services. Inter-sectoral linkages/interactions exist between the private sector and other players in the health system as well as intra-sectoral linkages between private sector players. These can be through referrals, interpersonal bonds with doctors working in the formal sector, interactions resulting from government training programmes (Gautham et al., 2014) and through dual practice (McPake et al., 2002, Roenen et al., 1997).

Having reviewed all the literature, the researcher then developed a conceptual framework for this study. The conceptual framework provided the basis for understanding, analyzing and designing ways to investigate relationships in health or social systems. It guided the emphasis of the research objectives/questions, the research design and, to some extent, the interpretation and analysis of the findings.

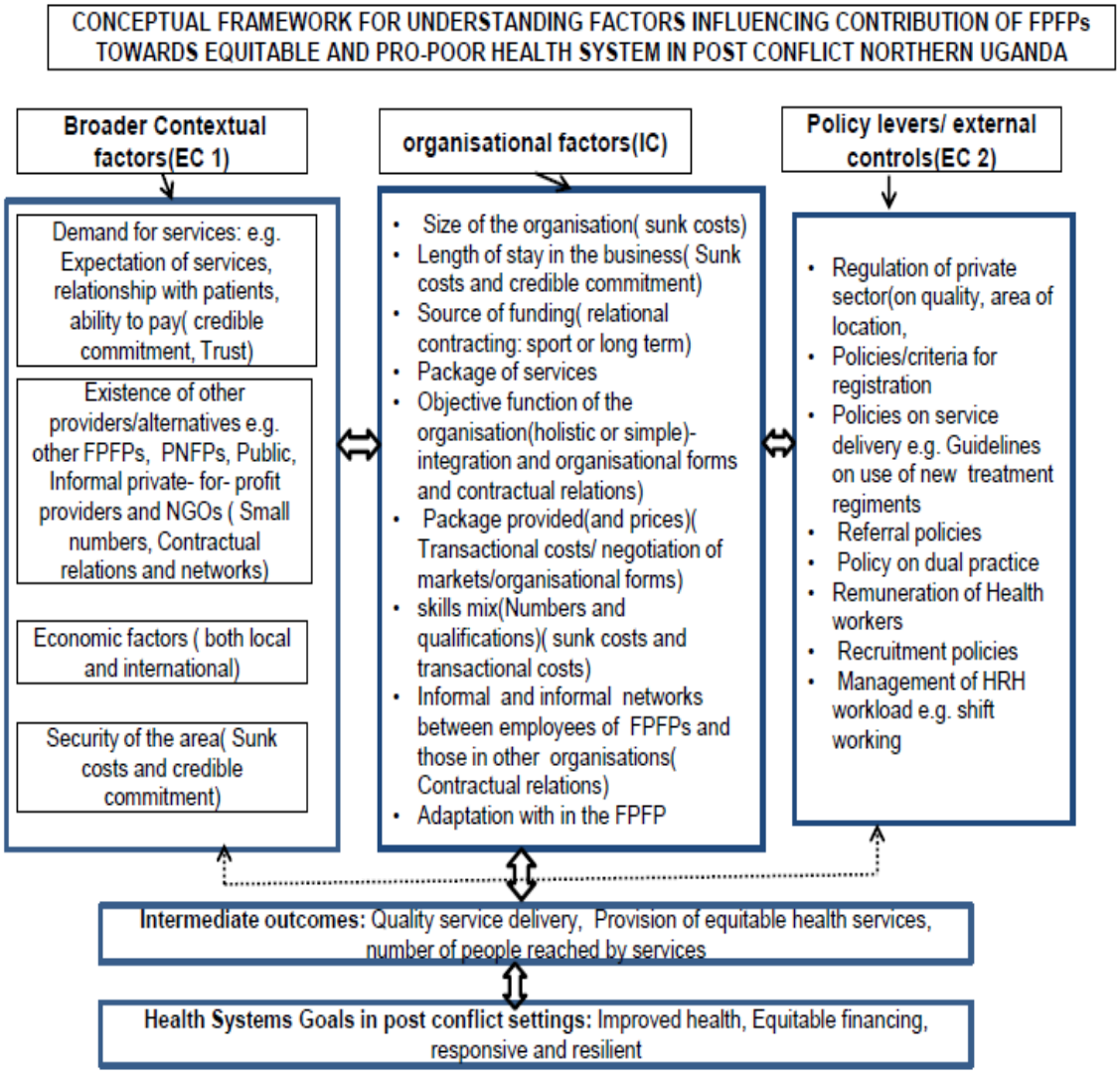
3.9. Conceptual Framework

The researcher developed a conceptual framework (Figure 9) based on insights from the literature reviewed combined with a composite of concepts borrowed from Elliot et al. (2008) framework (see Figure 8, sub-section 3.8) and from NIE theory. The framework emphasizes markets as complex systems (ibid.). The conceptual

framework shows that the factors influencing the contribution of FPFPs to equitable/pro-poor health systems are embedded in the context of operation and interactions between and within the context. As such, the context of the FPFPs has two components, the external context (EC 1 + EC 2) and the internal context (IC), where elements within each context interact with each other to produce an effect on FPFPs' contribution towards a pro-poor and equitable health system. EC 1 consists of the broader context comprising the existence and behaviour of other providers in the market/alternatives (Elliot et al., 2008) as well as security of the area, the demand for services, and local and international economic factors. EC2 comprises policy levers, i.e. nationwide or regional policies, which NIE term as external controls. According to Douma and Schreuders (2002), the internal environment (IC) of FPFPs comprises individual characteristics such as size, objective function and length of stay in business (sunk costs and credible commitment), skills mix, supervision, services offered (transactional costs), mission and internal adaptation.

FPFPs must interact with all these elements and rely on both formal and informal networks to survive. Networks enable the sharing of vital information and other resources, such as human resources for health and equipment, and may facilitate referrals. These networks reflect contractual relations in NIE and are based on the trust developed between individuals in different organisations. In this case, the larger organisations benefit from linkages between individuals.

Figure 9: Conceptual framework: Formulated by the researcher drawing on a composite of concepts from the literature



CHAPTER 4: METHODOLOGY

4.0. Introduction

This chapter presents the research design and methodology used to conduct this study. It begins with a brief discussion of the philosophical assumptions underpinning the development and implementation of the study. This study, as will later be indicated in this chapter, is a mixed-methods case study using a variety of data collection methods. Here, the chapter indicates the quant-QUAL sequence of the methods as well as the relationship between quant and QUAL methods – where the QUAL methods play a major role. A section on fieldwork and data collection indicating the study setting, fieldwork preparations and data collection methods comes next. The data collection methods are presented along with the rationale, selection of participants and how they were implemented. A discussion about the role of the researcher in influencing the process is indicated. The second last section focuses on ethics, the ethical clearance obtained as well as the ethical issues encountered and how they were managed. Lastly is a presentation about the data management and analysis process for both the quantitative and qualitative data. As indicated, the researcher used thematic analysis for qualitative data and used mostly ATLAS.ti, although, with the relational objective, a combination of UCINET and ATLAS.ti was utilised to help illustrate the visualized networks between FPFPs and other organisations.

4.1. Research Epistemology

Before conducting any study, the researcher needs to clarify the epistemological and ontological considerations. The epistemological perspective of a study refers to the

philosophical groundings about the nature of truth and the approach used to understand and explain reality (Crotty, 1998). The selection of an epistemological perspective of a study is important because it helps the researcher to shape the research design and makes explicit to others the phenomenon being investigated (Creswell, 2007).The main epistemological perspectives have been represented in varying ways by various scholars, with names often used interchangeably, and this is often confusing. However, for this study, three of the four categorisations presented in Creswell (1998;2007) (see Table 7) were considered and used as a basis for the selection of an appropriate combination (Creswell, 1998, Creswell, 2007) and then used to inform the choice of data collection methods. These include post-positivism, social constructivism, and pragmatism

Table 7: The four worldviews

Four World Views	
Post-positivism	**Constructivism**
• Determination • Reductionism • Empirical observation • Theory verification	• Understanding • Multiple participant meanings • Social and historical construction • Theory generation
Advocacy	**Pragmatism**
• Political • Empowerment issue-oriented • Collaborative • Change-oriented	• Consequences of actors • Problem-centred • Pluralistic • Real-world practice-oriented

Source: Creswell (2007), p. 6

Post-positivism

According to Creswell (2007), post-positivists argue that it is difficult to posit or be entirely objective when studying human behaviour (Creswell, 2007). Hence, they disagree with the traditional thinking predominant under positivism, which assumes

an absolute truth of knowledge, which can be posited and studied objectively for purposes of measuring reality and verification/testing theories. Despite their criticism, post-positivists continue to use the same assumptions as those of positivism (Phillips and Burbules, 2000). They still emphasise the need to employ a reductionist approach by reducing ideas into a small set of hypotheses and variables that are to be tested (Creswell, 2007). This view informs many quantitative approaches, which influence the use of experiments and closed-ended questions in a questionnaire to collect data. This view informed the researcher's choice of the organisational survey.

Social constructivism/interpretivism

The terms 'constructivism' and 'social constructionism' tend to be used interchangeably and subsumed under the generic term 'constructivism'(Charmaz, 2006). However, they are quite different. Constructivism proposes that each individual mentally constructs the world of experience through cognitive processes while social constructionism proposes that individuals construct reality in relation to the experiences of others within the society in which they live (Andrews, 2012).Therefore, reality is a social construct since it refers to the subjective experience of everyday life, [or] how the world is understood rather than to the objective reality of the natural world (ibid.).

Social constructivism originated from the classical works of Berger and Luckmann based on the social construction of reality (1991). They argue that knowledge is constructed by interactions among individuals within society (Berger and Luckmann, 1991). This view is consistent with that of Hamersley, who perceives reality as a social construct, one that is socially defined based on experiences of everyday life

(Hammersley, 1992). Social constructivists further argue that individuals attach varied subjective meanings to the realities that exist, based on their varied experiences (Creswell, 1998). This implies that to understand reality, the researcher needs to rely on participants' views to describe this reality (Guba and Lincoln 1988 cited in Creswell 1998; (Bryman, 2012). Based on this view, Creswell (2012) urges researchers to understand the context and/or set of participants through visiting the context and gathering the information themselves and also interpret what they find, based on their own experiences and backgrounds (p. 18).

Therefore, the social constructivist epistemology informed the understanding of the healthcare market in Gulu as experienced by the FPFPs and individual FPFP healthcare organisations. The researcher mainly used a variety of qualitative methods, with broad and open-ended questions to enable the participants to construct meaning through the various discussions and interactions. The researcher also visited Gulu municipality, a post-conflict setting where the FPFPs have been located and conducted the interviews herself.

Advocacy/participatory epistemology

Advocacy epistemology, which is sometimes referred to as 'participatory' or 'emancipatory', emerged in the 1980s and 1990s and can be found in the works of Marx and Adorno (Neuman 2000 in Creswell 2007), Fay (1987) and Wilkinson and Kemmis (1998). Participatory research has a predominantly transformative and social justice concern (Van der Riet, 2008). Therefore, proponents of the advocacy epistemology argue that research subjects need to be emancipated and empowered to make changes in their lives (Kelly and Van der Riet, 2001). Unfortunately, neither the post-positivist nor the constructivists adequately contributed to this broader view.

Post-positivism is criticized for imposing theories and structural laws that do not adequately address issues of social justice. On the other hand, constructivism is a little better than post-positivism, because it enables the exploration of people's experiences. However, good points do not go very far, because inherent in constructivism is a lack of an action agenda (Creswell, 2007), a crucial input for advocacy.

Hence, advocacy focuses on the needs of people who are powerless in society and the need to have an action agenda which goes beyond the information generated to empowering participants to make changes in their communities. Therefore, research becomes a form of social activism, a 'social intervention' within which an idea and action are embedded (Kelly and Van der Riet, 2001).

Pragmatism

The term 'pragmatism' was derived from the Greek word, '*pragma'*, which means action, and which is the central concept of pragmatism (Pansiri, 2005). Pragmatism as a research paradigm is rooted in the contributions of the philosophical movement of pragmatism which originated in the late 19th century in the United States (Maxcy, 2003). The pragmatist scholars, who include Charles Sanders, William James and Chauncey Wright, rejected the traditional assumptions about the nature of reality, knowledge and inquiry. In particular, they rejected a notion that inquiry within social science could only be conducted using a single scientific method (Maxcy, 2003). This implies that knowledge should not be generated only on the basis of a mutually exclusive reliance on either positivism alone or constructivism alone.

Hence, pragmatist scholars argue that although there is an objective reality that exists apart from human experience, this reality is grounded in the environment and can only be encountered through human experience (Morgan, 2014, Tashakkori and Teddlie, 2008). Based on this understanding of the complexity of reality, pragmatists concern themselves with what works to solve the problem and also emphasize the use of various philosophical and methodological approaches to generate extensive knowledge about the problem or to answer the research question (Creswell, 2012, Tashakkori and Teddlie, 1998). This implies that researchers need to have the flexibility and the freedom to choose methods that best meet their needs and purposes (Creswell, 2007). The possibility of the dichotomous nature of objective and social reality also influences the possibility of researchers aligning themselves with or conducting research that is influenced by more than one epistemological view.

Application of pragmatism epistemology in this study

Based on the pragmatic principle, this research was influenced by both the post-positivist and constructivist worldviews. Accordingly, pragmatism provided the philosophical underpinning for using the mixed-methods approach and combining both quantitative and qualitative methods. The researcher chose a mixture of quantitative and qualitative methods to help her answer the research questions and also to interrogate a complex phenomenon, the market, as experienced by the FPFP sector in post-conflict Northern Uganda, about which little is known.

4.2. Research Strategy: Case Study Research Design

The study was informed by a case study design using mixed methods. These included organisational survey, organisational life histories, key informant interviews and observation.

A case study refers to an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not evident (Yin, 2003). The decision to use the case study design was guided by the ontological and epistemological view noted earlier. For instance, this study is informed by the interpretivist epistemology as well as the ontological paradigm. In this connection, Stake (1995) suggests that qualitative case study researchers should be informed by constructivism. This implies that knowledge is constructed rather than discovered (p.99). Thus, as indicated in Creswell (2012), the qualitative case study researchers are conceived as interpreters who work in partnership with the participants to co-construct reality (p.24).

Creswell (2008) advises researchers to determine the type of case study they want to undertake before conducting a case study. Stake (1995, 2005) highlights and distinguishes between three main types of case studies: intrinsic, instrumental, and collective. In an intrinsic case study, the researcher's interest is to understand a case. Therefore, the case itself is of interest. According to Stake (1995), the instrumental case study enables an examination of a case, with the sole aim of providing an insight into an issue or re-drawing a generalization. Therefore, the choice of a case itself advances the understanding of another interest. Lastly, in a collective case study, individual cases could manifest or not manifest some common characteristics. The cases are selected because understanding them will lead to a better understanding of the larger collection of cases.

This study is an adaptation of an instrumental case study, which focused on providing insights into the healthcare market in Northern Uganda during and after conflict using

a selection of FPFP categories. However, the researcher did not intend to refine any pre-existing theory as such.

The case study design has various advantages. It enables the researcher to:

1) Conduct a detailed investigation of phenomena within their context to provide an analysis of the context and processes, which illuminate the theoretical issues being studied (Hartley, 2004, Pacho, 2015)
2) Make sense of and contextualize explanations about the focus of the study by the research participants (Welch et al., 2011).
3) Helps a researcher to plan better for their research. For example, one knows in advance what the unit of analysis will be. It can be a single phenomenon, be it a single individual, programme or event (Leedy and Ormrod, 2005).

However, the case study design also has disadvantages and these have been mainly related to reliability, generalization and validity (Shareia, 2015). Because of the small samples involved in a case study, one of the main critiques about case study research as a qualitative method is the limited generalization of the findings (Yin, 2003, Maxwell and Chmiel, 2014).

Indeed, case study scholars (Bryman, 1995, Creswell, 1998, Yin, 2003, Bryman, 2012, Maxwell and Chmiel, 2014) have acknowledged the generalization of external validity as the *'common and perceived inadequacy'* of case studies.

However, some have also argued that case studies need to be evaluated on the adequacy of theoretical inferences rather than on generalization to a large population (Mitchell 1983 and Yin 1984 in Bryman 1995). Bryman (1995) notes that *'the aim is not to infer the findings from a sample to a population but to engender the patterns*

and linkages of theoretical importance' (p.173). This study utilised the holistic embedded case study design using mixed methods in a **quant→ QUAL** sequence. This sequence, according to Bryman (2012), means that the quantitative methods of data collection play a subsidiary role, although they come before the qualitative data collection methods of data, which comprise the main data collection approach. Details about this are elaborated upon in section 4.5.

4.2.1. Defining the case

The term 'case', in a case study, can relate to several things based on the researcher's interest, that is, the study objective and research questions (Baxter and Jack, 2008). According to Yin (2003) and Bryman (2012), the term 'case' in the case study is commonly associated with a location or site such as a community, department within an organisation, event/activity, programme or a person. Baxter and Jack (2008) note that a case can be bounded by context, time, scope, or geography. They further add that the definition of a case can also be guided/informed by the type of case study that is selected by the researcher.

According to Yin (2002), there are two to four types of case studies – single holistic design, single embedded design, multiple holistic design, and multiple embedded design. Yin further distinguishes between holistic and embedded designs, noting that they require one unit of analysis and multiple units of analysis, respectively.

In this case, a single embedded case study was employed as the specific case study design, where the focus of the case was the healthcare market during and after conflict. The unit of analysis was the experiences of the private for-profit healthcare providers of the market in Gulu municipality during and after conflict. To understand

the case, 10 FPFPs (five young and five old, respectively) were selected to represent the various categories of FPFPs in Gulu municipality and hence various experiences. These included the experiences of the managers within these FPFPs that provided an in-depth elucidation of the growth and survival of the FPFPs within the healthcare system in Gulu municipality, their challenges, coping strategies as well as opportunities. The selected sub-units also highlighted the possible relationships between FPFPs and other providers in the area and provided an insight into whether and how the formal private for-profit sector in Gulu municipality contributes to access by the poor to health services.

Boundary of the case: Merriam (1998) looks at the case as a thing, a single entity or a unit around which there are boundaries. Based on this view, Merriam advises researchers to delimit the boundaries of the case as a means of sharpening their focus (p.27).

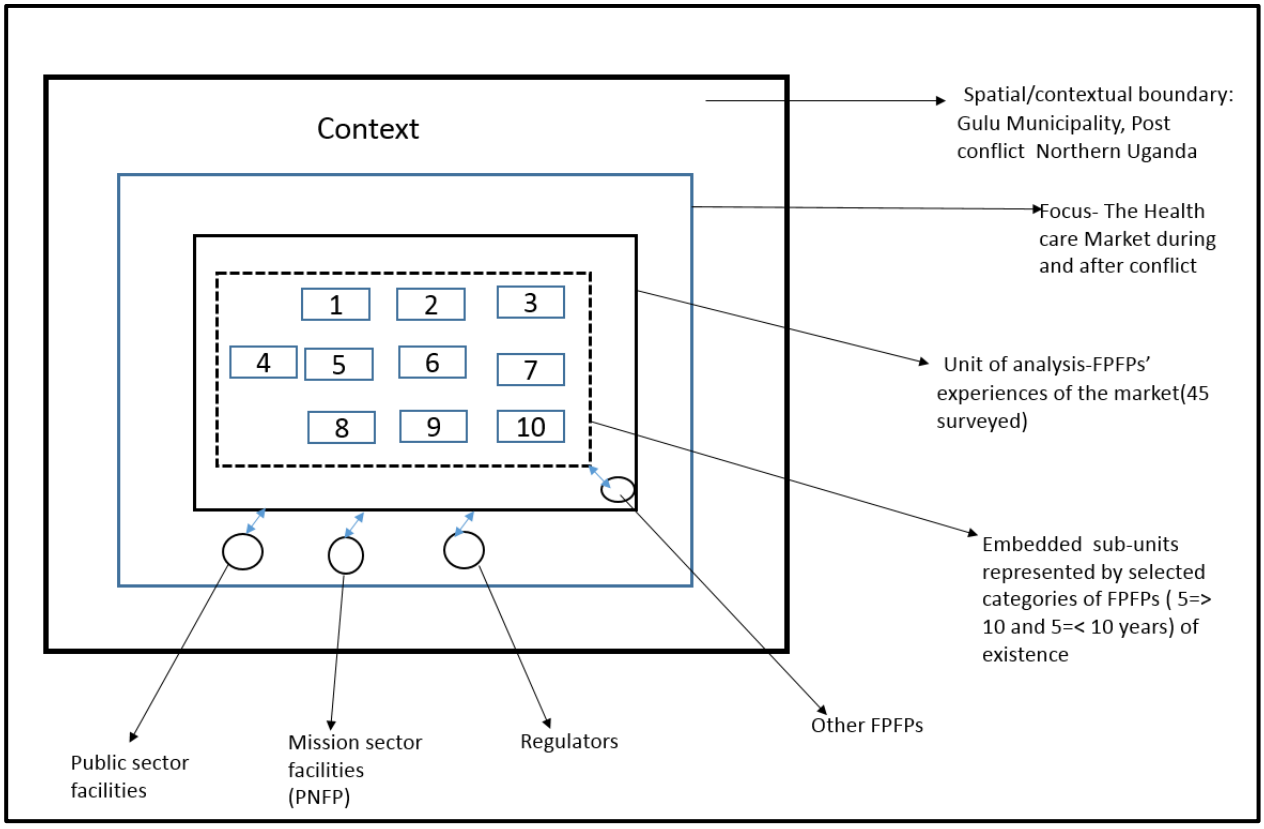
The *contextual/geographical boundaries* of the sub-units of the case in this study are defined by the geographical location of the study site (which is Gulu municipality, Northern Uganda).[18]However, a few key informant interviews were conducted in Kampala with *individuals and groups who regulate the sub-units.*

The temporal boundary, according to Creswell (1998), *is related to time (p.61).* In this case the boundary was twofold: 1) the age of the FPFPs selected as sub-units of analysis, which reflected two phases of the conflict, that is during and after conflict; and 2) the end of the data collection period in April 2015.

[18]The details about Gulu have already been provided under the section entitled ‘contextual background’.

The *population boundary* consists of individuals working within the FPFP, in facilities that relate with the FPFPs and those who supervise the operations of the FPFPs in Gulu municipality. The study population included managers of formal private for-profit organisations/businesses working in Gulu and health workers of formal for-profit organisations working in Gulu. Other participants included managers and health workers of other facilities that are not-for-profit (particularly private not-for-profit); managers of some public facilities; health workers working in the mission sector (PNFP) and regulators at the district and national levels. The study population also included 10 formal private for-profit organisations, which were sub-units for the focus of the study. The reasons for selecting the above categories of participants are detailed later.

Figure 10: Illustration of the case study and unit of analysis



4.3. Mixed Methods

Case studies have often been associated with qualitative research methods only (George and Bennett, 2005, Gerring J., 2004). However, Bryman (2012) argues that such an association is not very appropriate. Case study should not be a method, but rather as a design framework that may incorporate several methods. For instance, researchers conducting case studies can employ both qualitative and quantitative methods (Simons, 2009, Yin, 2009). Furthermore, the use of multiple sources of evidence is recommended when doing case study research (Creswell, 1998, Yin, 2003, Yin, 2009). Yin (1989 cited in Creswell 1998) and Yin (2009), for example, recommend up to six examples of sources.[19] According to Yazan (2015), advantages such as those indicated in a), b) and c) below accrue from the use of multiple methods:

a) Multiple sources of evidence, which may converge on the same set of facts or findings for the purpose of triangulation
b) A case study database (a formal assembly of evidence distinct from the final case study report which helps the novice researchers understand how to handle or manage data); and
c) A chain of evidence (explicit links between the questions asked, the data collected, and the conclusions drawn), which helps 'follow the derivation of any evidence, ranging from initial research questions to ultimate case study conclusions.'

[19]The six common sources of data for case studies include direct observation, interviews, archival records, documents, participant observation and physical artifacts (Yin, 2009).

Additionally, Bryman argues that multiple methods enable the researcher to offset limitations between the two types of methods (quantitative and qualitative) as well as enable completeness of data (Bryman 2006 cited in Bryman 2012). Therefore, using mixed methods enabled the researcher to probe or ask for clarification on information generated through other types of interviews. Table 8 shows a summary of methods and data sources and corresponding study objectives.

Table 8: Summary of methods, data sources and related study objectives

Research objectives	Sources of data	Analysis
1a. Characteristics of FPFPs b. Evolution and changes of FPFPs during and after the conflict	• Organisational survey • Observation • Organisational life-history interviews • In-depth Interviews • Key informant interviews	• Descriptive analysis (simple frequencies) using Excel • Thematic analysis using ATLAS.ti
2. Market dynamics for FPFPs a) Challenges and coping strategies b) Opportunities c) Relationships between FPFPs and others	• Organisational survey • In-depth interviews • Key informant interviews • Organisational life-history interviews • Document review	• Thematic analysis using ATLAS.ti • Social network analysis using UCINET software
3. Mechanisms by FPFPs to ensure that the poor access health services and how interaction with others influences FPFPs' contribution	• Organisational survey • In-depth interviews • Organisational life-history interviews • Observation	• Thematic analysis using ATLAS.ti
4.Suggestions and recommendations	Findings from 1-3 above	• Synthesis of 1-3

4.3.1. Sequencing of the methods

According to Creswell (2007), employing a mixed-methods approach involves collecting data either simultaneously or sequentially to understand research problems better. Sequential mixed-methods procedures are those in which the researcher seeks to elaborate on or expand on the findings of one method with another method (p.14).

However, as indicated by Bryman (2012), there can be up to nine ways of sequencing mixed methods (p.638). Although none of the scenarios is appropriate for this study, Bryman's classifications were used as a guide for developing a suitable one. Creswell and Plano also describe four designs for a mixed method design: the convergent parallel, the exploratory sequential, the explanatory sequential and the embedded design (Creswell and Plano, 2011). Although the explanatory sequential design was a little closer to the study, it was not necessarily the best fit. With this guidance in mind, this study adopted the **quant→ QUAL sequence** (Bryman, 2012), where the upper case and lower case indicate priority, and the arrow indicates sequence (p.638).

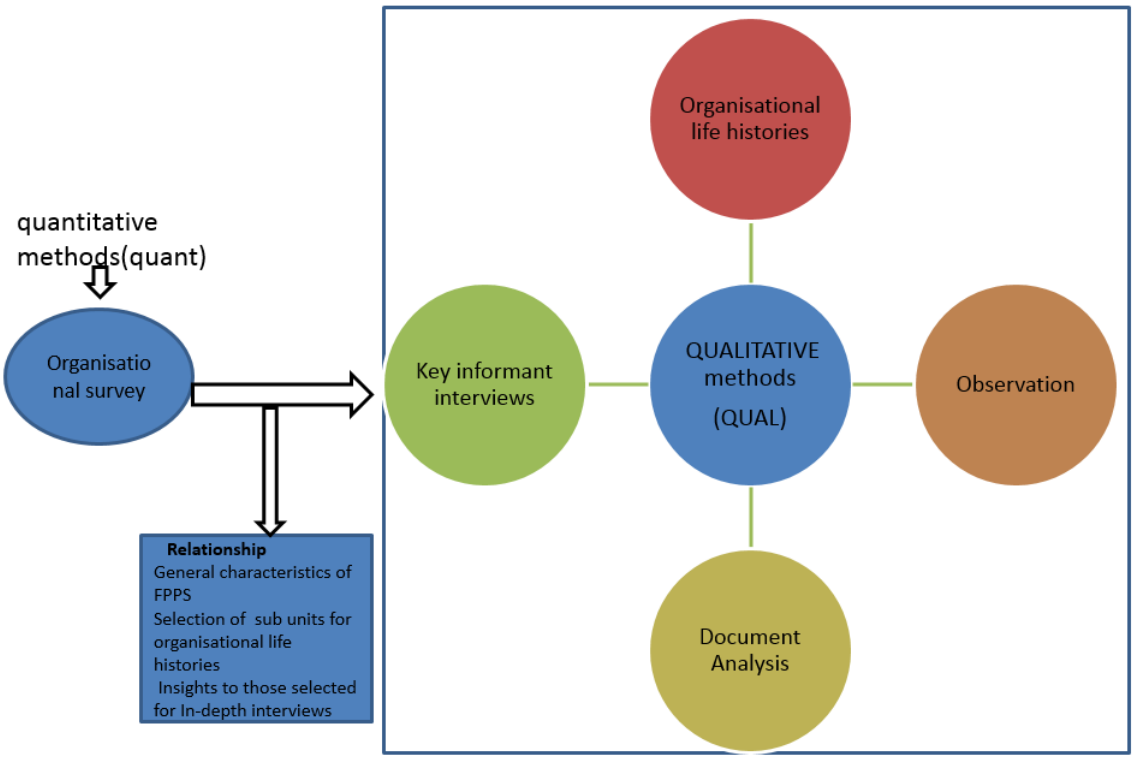
In the sequence above, two things characterize data collection: a) Quantitative methods precede qualitative methods; b) The quantitative methods play a subsidiary role, such as informing the selection of units (hence the reason why it is written in small letters, 'quant'); c) The qualitative methods comprise the main data collection approach, hence the reason they have been indicated as 'QUAL'; hence the study took an inductive approach.

Bryman (2012) advises that in relation to the quant-Quant sequence, quantitative methods can be used to facilitate case selection (Bryman 2006 cited in Bryman 2012). Although this study used a similar sequence, the quantitative methods, in this case an organisational survey was used to generate data on the description of the sub-units of the FPFPs' characteristics and to facilitate selection of the sub-units of analysis. Hence, the organisational survey acted as a mechanism for screening and identifying the FPFP sub-units. For instance, some of the selection criteria (such as

a), e) and d)) indicated in Table 10 were derived from the analysis of quantitative data generated in this survey.

Other relevant information that required further explanation and detail, for instance, information on the human resources, services provided, categories of clients served and information on informal relationships with certain listed other organisations (among others), was followed up in qualitative interviews. Probes were also made to check consistency and to fill the information gap. Figure 11 illustrates the sequencing of the data collection and the relationship between quantitative and qualitative methods.

Figure 11: Sequencing of data collection methods



4.4. Fieldwork and Data Collection

4.4.1. Study setting: Gulu district

This study was conducted in Gulu district during March-May 2015. Gulu district is one of the eight districts which form the Acholi sub-region in Northern Uganda. Other districts include Kitgum, Pader, Agago, Amuru, Nwoya, Lamwo and Omoro. Gulu district was selected purposively because it was and continues to be the hub of the region during the conflict. As a hub, Gulu attracted a relatively high influx of private healthcare organisations compared to other districts in the region.

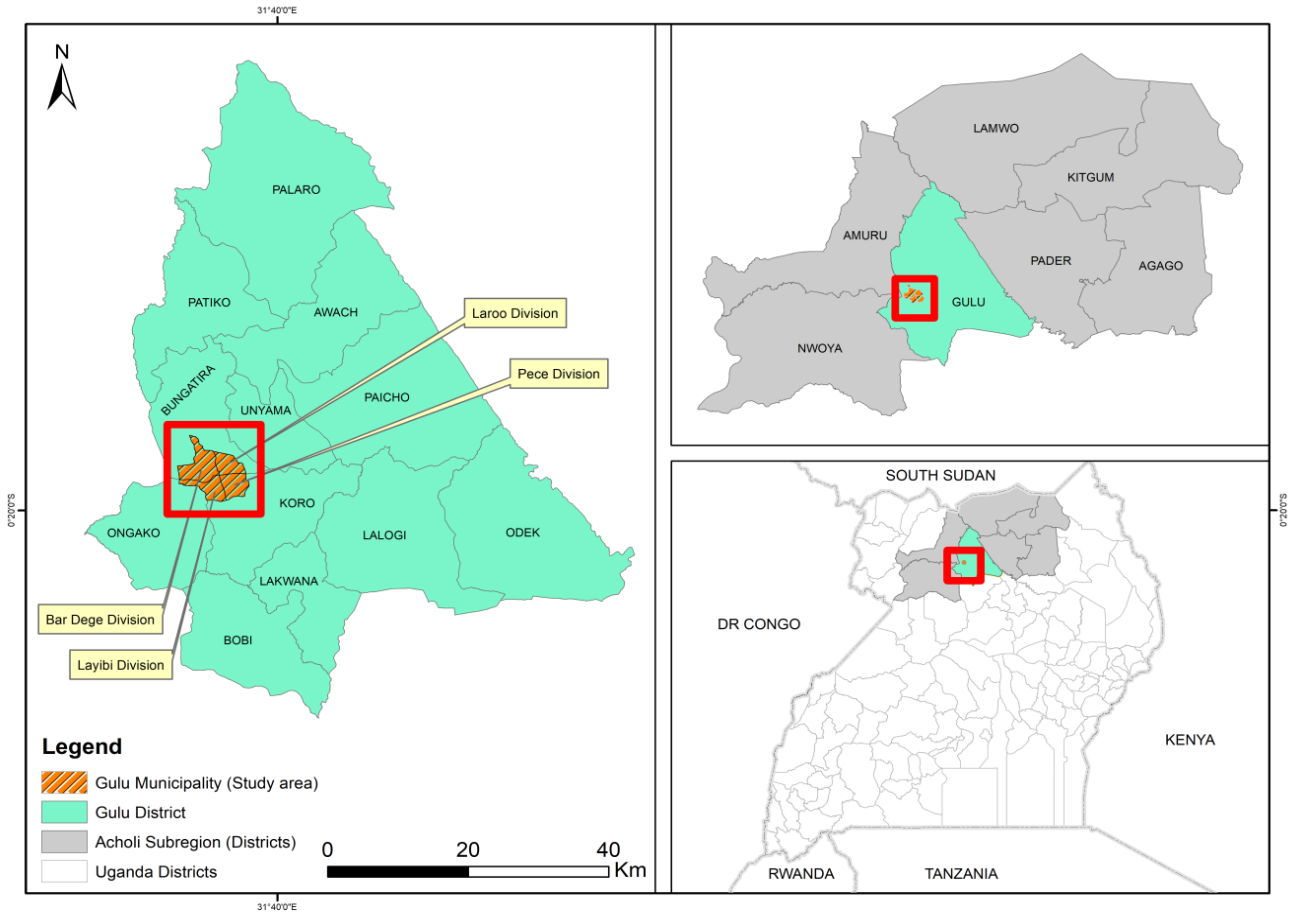
Gulu district is found in Northern Uganda between longitudes 30-32 degrees east and latitudes 02-4 degrees north. It is bordered by Amuru district to the west, Lamwo district to the north-east, Pader district to the east, Lira district to the south-east, Oyam district to the south and Nwoya district to the south-west (UBOS, 2013). The total land area of Gulu district is 3,449.08 sq. km (1.44 % of the Uganda's land size), of which 96.9 sq. km is open water. The district headquarters is 332 km by road from Kampala and through the Great North Road, which enables access to South Sudan and the DRC (UBOS, 2013).

Administratively, Gulu district comprises one municipality (Gulu municipality) and counties, namely Aswa and Omoro. Gulu municipality, commonly abbreviated as GMC, is the most urban of the four administrative units, the smallest and but also the most densely populated. For example, the 2013 population projections indicated that the Gulu municipality population was 163,100 while Omoro and Aswa had 143,400 and 101,000 people, respectively (UBOS, 2013). Branch (2013) attributes the high population in Gulu municipality to the massive influx of populations to town during the

war, given that the town remained relatively stable compared to rural areas. The rural areas were characterised by internally displaced persons (IDP) camps, given the movement of populations to towns during the war (Branch, 2007, Branch, 2013).

Figure 12 shows the four divisions that make up Gulu municipality, namely Bar-dege, Laroo, Layibi and Pece (UBOS, 2013). Each of the counties is sub-divided into several sub-counties/divisions, making it 16 sub-counties all together.

Figure 12: Map showing location of Gulu and Gulu municipality



4.4.2. Health indicators for Gulu district

The health system in Gulu follows a hierarchical structure like that at national level, except that there is no regional or national hospital. The levels of care under the public

sector include health centres I, II, III, IV and a hospital. Other providers of healthcare services include PNFPs and FPFPs. The district seems to be performing well in certain indicators, and even beyond 100 per cent around immunisation coverage. In 2015, Gulu was among the best performing districts in Uganda (MOH, 2015). By 2015, malaria was the leading cause of mortality in Gulu, followed by pneumonia, intestinal worms and diarrhea (Gulu District Local Government, 2015). The situation had remained relatively the same during the 2015 study period. Table 9 summarises the basic health information for Gulu district for 2015.

Table 9: Basic health-related information for Gulu district FY 2015

Issue	**Data**
Functional health facilities 4 Hospitals, 2 HC IV, 17 HC III and 62 HC II	86
% health workforce staffing level (compared to approved positions)	87
OPD attendance capita	2.2 per person per year
% of those with 4th antenatal care visits	46.1
% immunisation coverage	161*[20]
% deliveries at health facilities	89.3
% HIV prevalence	7%
% latrine coverage	72.1
Position at league table (year 2015)	4th

Source: Gulu District Local Government Plan (2015)

4.4.3. Fieldwork preparations

The researcher used existing networks developed over the last six years as a field coordinator for all ReBUILD Consortium studies. An initial field visit was undertaken in February 2015, during which the researcher paid a courtesy call on the District

[20] This is because of disease outbreaks and massive campaigns

Health Officer (DHO) and informed him of the intention to research the topic. She also requested him to provide the list of registered[21]private for-profit healthcare organisations in Gulu, which would later be used as a sampling frame for the survey. The DHO, Gulu advised her to contact the laboratory and clinic supervisor for the updated list of formal private for-profit healthcare organisations. Before preparing for the key informant interviews, the researcher had already secured the telephone contacts of most of the participants as well as the physical addresses of their offices. Hence, it was easy for the researcher to visit to make appointments in person and to confirm by telephone.

4.5. Data Collection Methods and Procedures

The research methods used in this study have been illustrated in Figure 11 and summarised in Table 12. These include organisational survey, organisational life-history interviews, in-depth interviews, key informant interviews, document reviews, and observation. The organisational survey came first and then were followed by the qualitative interviews.

4.5.1 Organisational survey

Bryman (2012) defines a survey as a type of cross-sectional research design whereby data is collected by questionnaire or by structured interview on more than one case at a single point in time in order to collect a body of quantitative data in connection

[21] Registration entailed payment of an annual operation licence fee and then completion of a form, which was downloaded online or physically picked up from the district health office. The form also provided for questions about the location of the facility as well as the owner of the facility and telephone contacts. Furthermore, the person registering the clinic had to pay their membership fee. This would then enable a manager of the FPFP to have their organisation added to the list and entered in the district database (see annex).

with two or more variables to enable detection of patterns of association (Bryman, 2012: 60).

The advantage of surveys is that they enable data collection from a large population within a short time. Questions can also be standardized (asked in the same order and same manner) for all respondents to allow comparability of responses from all respondents (Bryman, 1995). Survey questionnaires are also quick to code and analyse.

4.5.1.1. Selecting organisations for the organisational survey

For the organisational survey, a list of all the registered FPFPs, which was provided by the laboratory supervisor in Gulu district, was used as a sampling frame. All the organisations that appeared on the sampling frame were visited for an interview. Out of the 60 organisations that appeared on the list, only 45 participated in the survey. The remaining 15 were excluded from the study based on two reasons: 1) having declined to participate; and 2) having moved business or having closed shop despite being on the list.

4.5.1.2. Conducting the organisational survey

An organisational survey was conducted using a structured questionnaire. The purpose of conducting the survey was twofold – first, to establish the characteristics of the formal private for-profit organisations in Gulu in the post-conflict period (part of research question 1) and, secondly, to facilitate ‘case screening’ (Yin, 2003) and inform case selection for the organisational life-history interviews. Managers or any other person delegated by the manager participated in the survey.

The organisational survey provided data on several issues. These included period and duration of existence, category of organisation, mission/values, operating hours, bed capacity, the package of services offered in general, and the package of services offered free of charge or at a reduced price. Other issues included the categories of patients targeted, the number of staff and skills mix, among others, which other providers they had relationship/linkages with, and the resources exchanged with other organisations/providers in the area or beyond. The interviews lasted for approximately 40 minutes.

4.5.2. Organisational life history[22,23] interviews

A life history is a type of in-depth interview which enables a subject to narrate a chronological story of their lives while highlighting key events/turning points along the life course as perceived by them with the guidance of the interviewer (Atkinson, 1998, Bird, 2008, Bryman, 2012). Historically, life histories have been used to study the lives of Polish immigrants (Plummer, 1983: 64 cited in Bryman, 2012), patient groups (Cole and Knowles, 2001, Miller, 1994), the nursing profession (Cole and Knowles, 2001, Leininger, 1985), the history of neighborhood organisation (Yin, 2003), and poverty and well-being (Bird, 2008). Most recently, life histories have been used to study health workers' experiences of living and working through conflict (Namakula and Witter, 2014). Over time, modifications have been made to the life-history interview, particularly concerning the use of a timeline/lifeline. A timeline is a horizontal line drawn on a piece of paper or on the ground by the storyteller or the interviewer to facilitate probing by the interviewer, jog the memory and check the

[22] The term ‘life history’ is sometimes used interchangeably with ‘life story’.
[23] The interviews are termed as ‘organisational life histories’ because they will be focusing on the lives of the organisations as perceived by the respondents rather than the lives of the respondents.

consistency of responses during the interview (Namakula and Witter, 2014, Bird, 2008). At the end of the interview, timelines can act as summaries for the interview and can facilitate analysis.

The life history method enabled the researcher to conduct a retrospective inquiry into the 'lives' of the FPFPs across different phases – and after the conflict. It also enabled the researcher to map the different aspects of growth as well as the survival and challenges of these businesses across the conflict phases. The main disadvantage of the life history method is that it is usually long, running for 1-3 hours, and can yield much data that is difficult to transcribe and analyse.

4.5.2.1. Selection criteria for sub-units of analysis

Given the sequential nature of the data collection noted earlier, the data from the organisational survey informed the case selection for the life histories. Silverman encourages researchers to think critically about the parameters of the population being studied, based on which the purposive sample can be selected (Silverman, 2005). Hence, the researcher developed a list of attributes, indicated in Table 10, to guide the purposive sampling of sub-units of the FPFPs/organisations for their life history from the available data generated from the organisational survey. Additionally, the researcher ensured that the sub-units of analysis were representative of the various categories of FPFPs.

Table 10: Parameters/inclusion criteria of 10 sub-units of the FPFPs/organisations selected for in-depth study

a) Registration: They should be registered private for-profit organisations/entities. To this effect, only those that appear on the list of those registered/sampling frames for the quantitative component were considered for selection.

b) Location: They should all be FPFPs located in Gulu municipality, to provide a linkage to conflict as a context. Hence, the district and region are used to define what Creswell calls the 'contextual/spatial boundaries' of the sub-units of the FPFPs (Creswell, 1998: 61).

c) Age: Age was a temporal boundary (Creswell, 1998: 61) for the selected sub-units of the FPFPs. Here, age refers to years of existence and operation in Gulu and corresponds with the period during the conflict or after the conflict.

d) Category of organisation: The research tried to represent a diversity of each of the categories of FPFPs that would have been mentioned in the survey if the categories met criteria a) and b) above.

e) Ownership of organisation: The researcher also tried to include sub-units of the FPFPs according to ownership. For instance, the selection included individually owned FPFPs as well as those that are group-owned. This was to ensure variety and diversity. However, this was also dependent on whether they met criteria a) and b) above and was based on results from the organisational survey.

As a result, 10 sub-units comprising five old and five young FPFPs were included for life histories. The 'old' organisations were those that had existed in business within the area for more than 10 years (>10). The purpose of including such organisations was to enable the researcher to capture the experiences of FPFPs/track evolution,

growth, survival, challenges, coping strategies, and opportunities across different phases of conflict – during the conflict and after or even beyond.

The 'young' organisations were those that had established business in Gulu municipality after the conflict (after mid-2006). These were less than 10 (<10) years old. The purpose of including such organisations was to enable the researcher to highlight reasons for the hypothesized expansion of the FPFP organisations in Gulu municipality after the conflict. Where possible, the researcher sought to have some comparisons between challenges, survival strategies, coping mechanisms as well as opportunities of the old and young organisations.

4.5.2.2. Criteria for selection of study participants for life-history interviews

The criteria for the selection of study participants varied according to the type of interview to be conducted. Facility managers of the selected sub-units of the FPFPs who were to participate in life-history interviews were selected based on the position they held in the FPFPs (either as managers or owners of businesses). They were also selected based on the period they spent working in those organisations, i.e. at least 10 years and above for 'old' organisations and, in the case of the 'young' FPFPs, since the business was first opened. Like in the cases of the FPFP managers, the other health workers in the sub-units of the FPFPs were selected based on the period worked[24] and, therefore, had comprehensive knowledge about the business. Some health workers of FPFPs working in Gulu were selected based on their working experiences in old or young organisations, which is >10 or <10 years, respectively.

[24] They should have worked in the organisation since its inception/establishment.

4.5.2.3. Conducting the life-history interviews

Using a semi-structured in-depth interview guide with open-ended questions, organisational life-history interviews were conducted with current managers of selected FPFPs to uncover the turning points/key events in the life cycle of the organisations since their establishment. The guide was developed based on the questions depicted by *Yin (2003)* in the *'case study of a neighborhood organisation'* (pp. 13-52).[25] However, some adaptations were made to suit the context.

During the interview, the researcher would ask some questions to break the ice and then explain how the interview would be followed through. A timeline was drawn and then the researcher asked the participant to talk about the key events in the life of the organisation/business. In most sub-units of the FPFPs, the interview started with the opening of the business and the reason/decision to open the business. The discussion was then followed by some aspects of growth, e.g. *growth in size, bed capacity and staff numbers*. As most FPFP managers were reluctant to talk about their profits, the researcher used proxies such as the number of clients attended to to bring out indicators of profit. Probing questions were made across the timeline to seek clarifications as well as consistency. The interview was iterative, going back and forth across the timeline. At the end of the interview, the participants were asked to look at the timelines and check which information to correct or include what could have been missed. Each life-history interview generated a transcript but also a timeline as a visual summary of the interview. The duration of the life-history interviews ranged

[25] See annexes for sample questions that will be in the semi-structured interview guide for the life-history interview.

from 1.5 to 2.5 hours, with those for ‘old’ organisations taking longer than those for young organisations.

4.5.3. Key informant interviews

Key informants are chosen because they are believed to have the most knowledge of the subject matter (Parsons, 2011). In a mixed-methods case study, they may be selected for purposes of triangulation of findings with other methods (Yin, 2009; Bryman, 2012). In this study, key informant interviews were used for purposes of gathering key information that would not have been identified by the managers who participated in the life-history interview.

4.5.3.1 Selection of key informants

Key informants were comprised of regulators at district and national levels, individuals who worked in other FPFPs (outside the 10 selected for in-depth study) as well as managers and health workers from the mission sector/private not-for-profit and managers of some public facilities. Key informants were selected purposively based on their experiences derived from having worked in the region for a long time (above 10 years), working in other facilities in the market in Gulu or in positions of authority in relation to the supervision of FPFPs. Some of the participants, particularly the regulators, were included following recommendations from other interviewees.

Using a semi-structured interview guide, key informant interviews were conducted with health workers in PNFPs, public facilities, and some private for-profit facilities to gain an insight into the informal relationships between their facilities and the private for-profit sector in general as well as perceptions of the FPFPs in Gulu.

Further key informant interviews were conducted to gain further insights into the experiences of coordinating FPFPs, regulating FPFPs, working with FPFPs as well as general perceptions about the potential of FPFPs. These were conducted with members of the district health team, including, for example, the District Drug Inspector (DDI), the regional Allied Health representative, the inspector for laboratories, the coordinator of the PPP office, and the inspector for clinics. These were interviewed based on the advice of the DHO. Other members who were interviewed at the district level included the town clerk and executive directors/representatives of professional councils.

The DHO advised that, rather than interview him, the coordinator for laboratories, the district drug inspection officer, the coordinator for Allied Health and the coordinator for clinics, pharmacies and drug shops should be interviewed, as they would provide the most relevant information for the study. Some of the participants were selected following recommendations from other interviewees. The duration of the key informant interviews ranged between 45 minutes and one hour.

4.5.4 Document review

Document analysis is one of the six methods that Yin (2002) proposes for a case study. Documents can provide information which may triangulate or supplement views from the interviews. To provide a background to the topic, official documents were analyzed. Thus, national reports and district reports were reviewed to understand issues related to the regulation of the private sector and the engagement of the private sector in health service delivery at the district level. The researcher had requested FPFPs to provide selected documents, such as internal reports (annual or monthly). However, the majority were reluctant to share them. Instead, they preferred

telling their story and merely sharing non-sensitive/ marketing information such as brochures, which indicated the services provided. In this case, the memos on the noticeboards of the various FPFPs were analyzed as well.

4.5.5. Observation

Observation is a data collection method which is most strongly associated with ethnography and applies to experiments. Using observation, a researcher systematically observes/looks, records/notes, describes, analyses and interprets phenomena in the social setting of the study as they occur (Kawulich., 2012, Davies, 1999, Ritchie, 2003). Table 11 summarises the advantages and disadvantages of the observation method.

Table 11: Advantages and disadvantages of observation method

Advantages	Disadvantages
1. May enable you (the researcher) to access those aspects of a social setting that may not be visible to the public – those backstage activities that the public does not generally see.	You may not always be interested in what happens behind the scenes
2. Observation gives a researcher an opportunity to provide rich, detailed descriptions of the social setting in field notes and to view unscheduled events, improve interpretation, and develop new questions to be asked of informants	Your interpretation of what you observe may be hindered by several factors – participants may only permit you to observe situations that you already know
3. Limited researcher bias	Observation does not solely involve watching others; it also involves asking questions to ensure that your interpretation of what you observe is really what is going on and this may imply bringing in your researcher bias as you ask questions

There are two main types of observation, namely participant observation, and structured observation. Participant observation, which is a common practice in ethnographic research, involves the long-term personal involvement of a researcher with the research subjects (ibid.).

Structured observation, on the other hand, is concerned with the frequency of event. It is characterised by a high level of a predetermined structure of observing phenomena and is used for measuring the occurrence of phenomena for purposes of quantitative analysis (Bryman, 2012).

Whereas a distinction is provided, some scholars have argued that there is a thin line between participant observation and mere observation, given that the researcher may find themselves participating, for instance, by asking questions. Such a situation opens the door to researcher bias (Ratner, 2002). This study adopted a mix of participant observation and structured observation. This is because the researcher not only drew up a list of things to observe but also, once in the field, found herself participating in some of the activities that were going on and also asked some questions after making some observations during the interviews.

The researcher observed certain aspects of the physical environment of the FPFPs, such as the physical structure, signposts, posters and nearby surroundings, general cleanliness as well as the interaction between the health workers in the FPFPS and their clients. She then filled in the spaces on a structured and pre-typed sheet with structured questions. In some instances, the researcher abandoned the observation checklist and resorted to writing detailed notes on the back of the checklist.

Observation enabled the researcher to gather firsthand information that may not have been in the organisational documents. It also provided an insight into the day-to-day experiences of those working in FPFPs and the category of clients being served. For instance, this included the infrastructural size of a FPFP, the range of services provided as well as the general advertisement mechanisms (noticeboards and signposts), marketing strategies and directions around the facility. Observation of general cleanliness was also undertaken as a proxy to enhance the understanding of environmental quality. Ritchie notes that observation offers the opportunity to record and analyse behaviour and actions as they occur (2003: 35). This was true of the observation of the interaction between health workers at FPFPs and their clients.

The researcher spent a minimum of one day observing each of the 10 FPFPs selected for in-depth study. The researcher would visit the facility in the morning, and then return in the evening of the same day or in the afternoon of the following day, depending on which was preferred. During the observation, the researcher would make notes in the spaces left in the observation sheet, for different parameters. A note on general observations was made.

4.5.6. Total number of interviews conducted

As a result, 45 semi-structured survey interviews, 10 organisational life histories, 13 key informant interviews and observational notes were gathered. Table 12 summarises the type, number of interviews and categories of respondents.

Table 12: Summary of interviews and category of participants

Category of method	Number of interviews	Participant category
Organisational survey	45	FPFP managers or any other person delegated by the manager
Life-history interviews	10	FPFP managers and in some sub-units of the FPFPs, a long-serving member or co-business owner
Key informant interviews	13	District drug inspector (DDI), regional Allied Health representative, inspector, laboratories, coordinator, clinics, executive directors of professional councils, Town clerk Others included managers in PNFP and public facilities s as well as Health workers in PNFP, Public facilities, and some other private for-profit facilities that were outside the sub-units of analysis
TOTAL	68	
Observation (PO and structured)	10	Ten FPFPs observed, notes taken, and checklist completed
Document review	Over 200	

4.6. Data Management and Analysis

4.6.1. Management and analysis of quantitative data

A database was generated from the structured questionnaires. Data was captured and entered in Excel spreadsheets and then exported into Statistical Methods for Social Sciences (SPSS) analysis software. Descriptive statistics were then generated based on the questions in the survey questionnaire

4.6.2. Management and analysis of qualitative data

As advised by Silverman (2005), analysis of qualitative data began in the field (Silverman, 2005). After every interview, the researcher reviewed data, and reflected upon the research questions to identify gaps where further probing/follow-up needed to be done in the subsequent interviews.

Furthermore, analysis of qualitative data was guided by the framework approach (Ritchie and Spencer, 1994) and the organisation of data was further assisted by ATLAS.ti version 7.0. Framework analysis adopts an iterative approach and involves the following stages: 'familiarisation, listening to audio recordings, reading field notes, coding and identifying key themes, merging themes, searching for key findings, finding associations and providing explanations for the results' (Ritchie and Lewis., 2003).

Audio recordings were transcribed verbatim so that original quotes were not lost. The audio recordings were also compared with the notes taken during interviews to fill in any gaps in information that could have been left out or mis-recorded during the interview. The interviews were then filed using identifiers emerging from the data. Transcripts were read several times to allow familiarisation with the data and enable the identification of recurring themes. A coding framework was developed, and the transcribed interviews were entered in ATLAS.ti software and coding nodes were attached to the various themes. ATLAS.ti query reports were generated and printed out for each theme. Furthermore, the query reports were scrutinized for emerging sub-themes and quotations that epitomize the central themes were identified. Findings were then synthesized across the main themes, and patterns and differences across different organisations were noted.

4.6.3. Social network analysis

Research question 2(d) focused on understanding the dynamics of the healthcare markets in which the FPFPs operate. Research question 3(d) also focused on how the relationships enabled the FPFPs to make their contribution. Hence, the

researcher was interested in understanding the relationships between FPFPs and other organisations to understand how healthcare markets thrive and sustain exchanges/transactions. Accordingly, some relational questions were also asked during the interviews across the survey questionnaire, key informant interviews and life-history interviews. The researcher chose to use Social Network Analysis (SNA) to illustrate the relationships and the networks which could emerge because of these relationships

SNA has the following advantages:

- It enhances the possibility of revealing social network data embedded in qualitative interviews (Mckether et al., 2009).
- SNA can help anthropologists to improve their analysis and reporting of ethnographic data, thereby expanding the methodological tool kit traditionally used by anthropologists (Mckether and Friese, 2016).
- SNA enables the researcher to examine the relationships (also referred to as links, edges or ties) which an actor or actors (referred to as nodes, alters or vertices) have with other individuals, groups or organisations in an environment (Mckether and Friese, 2016).
- SNA helps depict the structure of a group by examining important relationships reflected in the strength, direction and complexity (or number) of ties embedded in a network (Wasserman and Faust, 1994).

Under this analysis, in this study, the researcher was interested in ego-centred networks. Ego-centric networks are those that focus on an individual who describes people/organisations (alters) close to him or her (Wellman and Berkowitz, 1988) and

his/her connections. For this study, the FPFP was the ego while those that were mentioned were referred to as 'alters'.

4.6.4 Analysis process for the relational objective

The analysis process for the relational objective followed the process as presented in (Mckether and Friese, 2016) although with some modifications.[26] McKeither and Friese first developed a special coding frame for the relational objective, and then coded the data in a new ATLAS.ti file. They then extracted the relational links that arise out of the data coded into ATLAS.ti and then exported it to UCINET.

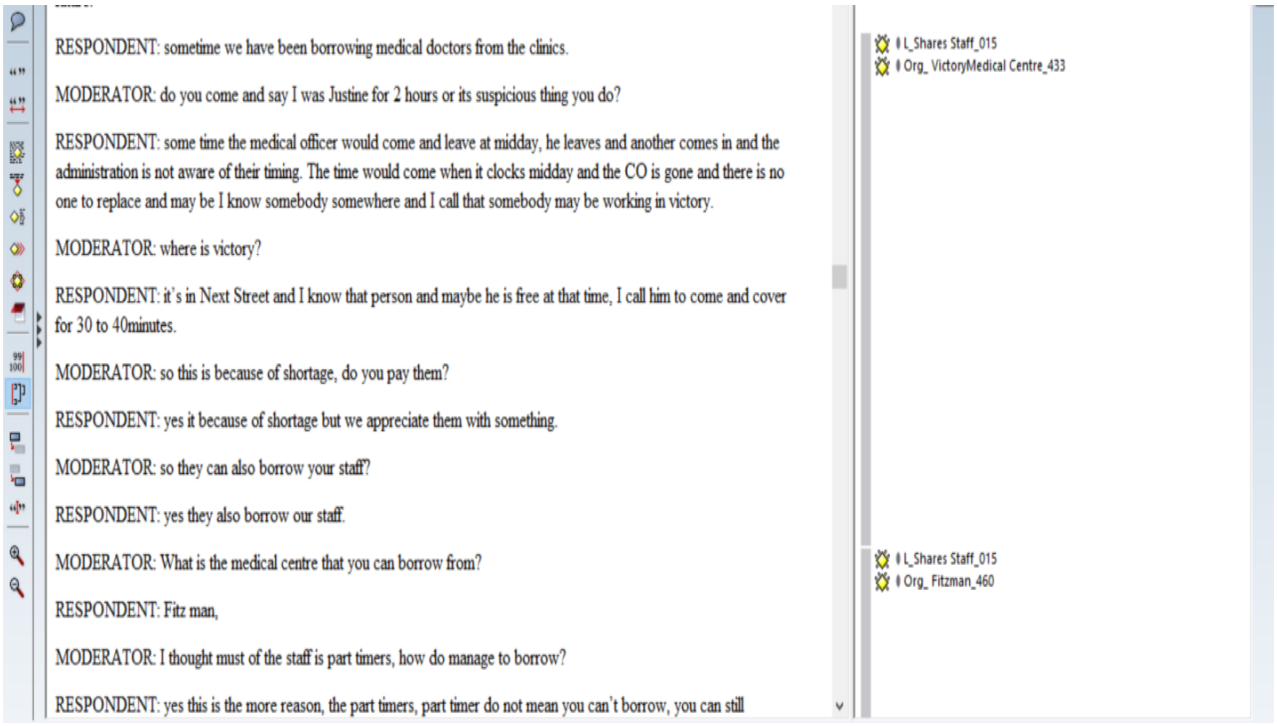
Table 13 indicates a separate coding frame which was developed for the relational objective and interviews coded again into ATLAS.ti, while identifying organisations and individuals to which FPFPs are related as well as the relational links between FPFPs and other organisations and individuals. For each organisation mentioned and relational link identified, a three-digit numbers from 400 through 464 and 001 through 035 respectively and then coded into ATLAS.ti, with the words added by mere separation with an underscore.

Table 13: Codes for names of organisations and relational links developed for ATLAS.ti

Nodes	Object in ATLAS.ti	Numbering scheme	Code generated in ATLAS.ti – with examples
Names of organisations mentioned in interviews (including those being interviewed)	Name code	400-464	Org_FLAMAUganda_400
Names of people mentioned in interviews	Person code	001-007	N_LastName_First Name_ID Number Example: N_Nathan _ Akello*_001
Relational link	Link code	001-035	L_Link Relation_ID Number Example: L_we refer to them_011

[26] The network maps were not created with in ATLAS. Ti but within Net Draw (which is a platform for developing networks within UCINET software.

Figure 13: An extract of coded data for relational objective – interview with a medical centre



Source: Researcher's ATLAS.ti Hermaneutic project

The relational links were then summarised into Excel to generate a descriptive graph and later exported to UCINET to generate network illustrations. After coding in ATLAS.ti, the researcher had to prepare the data further for input in UCINET. An Excel file was developed indicating 1) the organisations being interviewed; 2) the organisation that has been mentioned; and 3) the relationship/link that exists between the organisations. At this stage, the researcher further shortened the relation link name to one word/compound word and then created a comment column explaining what exactly was being exchanged between the two organisations. This would help later in the write-up. Additionally, the researcher merged some of the 35 relational links into 14 broader categories and later seven categories whereas the remaining

relational links, including links with individuals and between organisations that were already linked to FPFPs, were clustered into the ‘others' category.

Separate matrices were created for general network and seven relational links that had been mentioned 10 times and above. The researcher decided to sort the data (by clicking on the filter function in Excel) and then select all similar links together with the organisations. For each of the selected relational links, a dichotomized square matrix with a list of all organisations that had appeared in the sorted sheet had to be generated.

These matrices or sorted Excel files were then imported into UCINET, then saved as a network analysis file ending with the extension ##h. The UCINET files were visualized Net Draw to create a socio-graph/network. For all the graphs, the circular layout was selected and then the colour codes edited and finally the file was saved as JPEG. Some of the files were saved as a bitmap to allow for further editing. Those network maps that had isolates – those that were not related to any other – were deleted from the network.

To identify the core organisations in the networks, the aggregated matrix for each of the relational links was subjected to the degree of centrality analysis, particularly the *degree of betweenness (Borgatti and Everett, 1999).* Betweenness centrality measures the extent to which a vertex lies on paths between other vertices and hence controls some information passing between others. Removal of such a vertex from a network causes a disruption (Borgatti and Everett, 1999).[27] The level of

[27]https://www.sci.unich.it/~francesc/teaching/network/betweeness.html

betweenness is illustrated by the number of arrows connected to a node, where the arrows are fewer, it implies high betweenness and where the arrows are many, it implies low betweenness. In relation to the study, some organisations within a given network had many links attached to them compared to other organisations, hence they had high betweenness and were referred to as the 'most central organisations'. The many links represent high influence within the network. Given their influence, the network would be disrupted if they were removed from a network. In the case of the FPFPs, those that were central were the ones with the high betweenness, those with many links, so that when the researcher attempted to remove them, many links were lost.

4.7. Reflexivity of the Researcher

Reflexivity is a continuous process of reflecting on how the researcher could be influencing their research project and also shapes the final outcome of the project (Hardy et al., 2001). It should be integrated into the whole research process right from conducting research through analysis to write-up. When doing research informed by the traditional positivist research paradigm (e.g. experiments), the researcher attempts to be neutral while collecting data. However, this may be difficult for research influenced by a social constructivist paradigm as researchers bring on board their interpretations and experiences in order to co-construct reality (Creswell, 2012) with the participants.

The researcher acknowledges that her experiences and her background as a social scientist and a person who had worked in post-conflict settings for several years shaped her access to participants and influenced her interpretations of the findings. The researcher's interest in the pro-poor agenda also influenced the questions that

were asked. Nevertheless, the researcher continued to be less judgmental of the FPFPs as she continued to analyse the findings interviews during and in-between interviews.

4.8. Ethical Considerations and Clearance

Ethical principles of social research enable researchers to 'do the right thing' (Ruane, 2005). Ethical principles that were adhered to in this study include informed consent, confidentiality, anonymity, do no harm and data storage. These principles have been articulated well by various authors of research methods (Ruane, 2005; Bryman, 2012). Ethical approvals/clearance were sought from the Queen Margaret University (QMU) Ethics Committee, the Makerere University School of Public Health Higher Degree Research and Ethics Committee (HDREC 279) and Uganda National Council for Science and Technology (UNCST) – SS 3795. Further permission to conduct research was also sought from the district health office and managers of the private for-profit organisations/facilities (Appendix 3).

Written informed consent to participate and record interviews was obtained from the individual study participants (Appendix 1). Anonymity and confidentiality for all information obtained were ensured using serial numbers and pseudonyms or codes in place of respondents or organisations. Additionally, broad terms such as 'young' or 'old' organisation were used to ensure that organisations/sub-units of the FPFPs are not identifiable when referred to in the thesis. All the collected data was saved, and password-protected and accessed only by the researcher.

CHAPTER 5: CHARACTERISTICS AND EVOLUTION OF THE FPFP SECTOR

5.0. Introduction

The findings in this chapter address research question (1), which focused on the description of the general characteristics of FPFPs in Gulu as well as the changes/evolution of FPFPs, during and after the conflict. The researcher used data from an organisational survey of 45 FPFPs as well as qualitative data sources such as life-history interviews and key informant interviews. The analysis draws on constructs from the neo-liberal theory (proliferation and free entry), the concept of evolution of organisations as well as NIE-related concepts such as sunk costs and credible commitment, among others. The chapter also draws on the stages of the organisational life cycle to analyse evolution among the FPFPs. The chapter is divided into two parts; 5.1 focuses on the characteristics of the FPFP sector while 5.2 focuses on the emergence of the FPFP sub-sector in Gulu as well as the evolution of the FPFP sector over time.

5.1. Characteristics of the Formal Private For-Profit Provider (FPFP) Sector

The 45 FPFPs surveyed had varying characteristics, which were categorised into 10 sub-themes, deducted from the questionnaire. These included registration, category of organisation, ownership[28], source of initial capital invested, age (duration of existence), package of services offered, staffing, the inpatient admission capacity

[28] This was derived from life-history interviews.

(where appropriate), the operating hours and number of days open in a week. These are explained in greater detail below.

5.1.1. Registration

To deliver services legitimately, all FPFPs were required to register with the district health headquarters to appear on the list. Fulfilment of this obligation required payment of annual licence fees for operation, suitability of the premises and displaying the licenses in the facilities. The researcher also observed that for most of the FPFPs, the annual licenses for that year (2015) hung on the walls, although many were not keen to keep and share records of the previous annual licenses, except for the drug shops. Regulation also required that all staff of the FPFPs, depending on their respective cadres, had to belong to a specific professional body, with an annual subscription. Although the researcher did not request certificates of membership during the interviews, the managers verbally acknowledged that this was the case for all their staff.

5.1.2. Categories of FPFPs in Gulu

The mini-organisational survey also showed a variety of categories of FPFPs in Gulu, including clinics, clinics with laboratory sections, pharmacies (exclusively retail or wholesale, a mixture of wholesale and retail), stand-alone laboratories, medical centres, private hospitals, insurance company clinics, and others. Others included drug shops, imaging, and medical X-ray centres, 'health centres' and NGO clinics. All health centres that were operating on a for-profit basis were at the HC II level.[29] As illustrated in Table 14, the majority of the FPFPs surveyed were clinics (18), followed

[29] This is the second level of facility within the public health system.

by drug shops and medical centres (7). There was only one private hospital, insurance company clinic[30], X-ray centre, NGO clinic and HC II, respectively. The majority of the FPFPs were located either along relatively busy streets within Gulu town.

Table 14: Categories of FPFPS

	q15 Category of organisation			
Code	**Organisation**	**Frequency**	**Per cent**	**Cumulative Per cent**
1	Clinic	18	40.0	40.0
2	Medical centre	7	15.6	55.6
3	Pharmacy	5	11.1	66.7
4	Laboratory	2	4.4	71.1
5	Private hospital	1	2.2	73.3
6	Insurance company clinic	1	2.2	75.6
7	Drug shop	8	17.8	93.4
8	X-ray and scan centre	1	2.2	95.6
9	NGO clinic	1	2.2	97.8
10	HC II (health centre level 2)[31]	1	2.2	100
	Total	**45**	**100.0**	

[30]These were two but one declined to participate in the study.

[31] Although this is a government designation, some of the FPFPs are awarded the same title if they satisfy the requirements for this level. This is after they pass the accreditation process. The requirements are summarised under the section on health systems components. On observation, there turned out to be many private providers at HC II, although the majority were private not-for-profit.

Photo 1: Some of the FPFPS in Gulu – Courtesy of Justine Namakula

5.1.3. Ownership and source of initial capital invested

There were two major categories of ownership of FPFPs – individual ownership and group ownership – with the former being more common. Sub-categories under group ownership were family-owned businesses or businesses owned by a pair or group of friends. In some cases where there was more than one owner, the strategy was to combine initials to form the name of the business. Regarding initial capital, the data indicated three main sources of initial capital for the FPFPs in Gulu: savings, funds pooled across a group of people and loans. Loans as a source of capital were more common among the relatively new FPFPs.

Savings were mainly from salaried jobs in the public sector or PNFPs as well as salaries from jobs in non-health-related sectors or savings from other businesses owned by the FPFP owner(s). Businesses whose initial income was a result of pooled funds across a group (not necessarily relatives) had experienced major changes in the past, i.e. a change in location and name after current owners disagreed with their

previous co-owners. Other challenges, such as lack of continued financial commitment and the presence of shareholders in some group owned FPFPs, also resulted in 'potential struggle'. This was the case with one clinic and one stand-alone laboratory:

> We joined resources and opened a clinic [in Pece] for some time and later we separated, and I opened-up my own in Layibi in 1985. (P18: LH_Medical centre_ Old FPFP)
>
> They had some shares, got the money, put it together and established a business. (P20: LH_ Laboratory_ Young FPFP)
>
> We got a loan. (P21: LH_ Clinic_ Young FPFP)

5.1.4 Age (duration of existence) of business

In this study, the age of business referred to is the number of years that a FPFP has existed since its establishment. The longest duration in business was 33 years, whereas the shortest was four months. Table 15 indicates that of the 45 FPFPs surveyed, only 12 FPFPs had existed between 10 and 33 years, and the majority were clinics. Throughout the finding's chapters, these are referred to as 'old FPFPs'. Thirty of the FPFPs had existed between 1 and 9 years, and the majority of these were also clinics and others, including drug shops, hence these were referred to as 'young FPFPs/organisations'. However, three of the organisations interviewed in the survey – two pharmacies and a medical centre – had been in existence for less than a year at the time of data collection. Accordingly, such organisations are referred to as being in the *'fetal stage'.*

Table 15: Age of existence for FPFPs

Category of organisation	Years of operation/existence			Total
	>1 yr. (*'fetal stage')*	**1-9 yrs (young org.)**	**10-33 yrs (old org.)**	
Clinic		11	7	18
Medical centre	1	5	1	7
Pharmacy	2	2	1	5
Laboratory	0	2	0	2
Private hospital	0	0	1	1
Insurance company clinic	0	1	0	1
NGO clinic	0	0	1	1
Drug shop	0	7	1	8
X-Ray, scan and medical imaging centre	0	1	0	1
HC II**	0	1	0	1
TOTAL	**3**	**30**	**12**	**45**

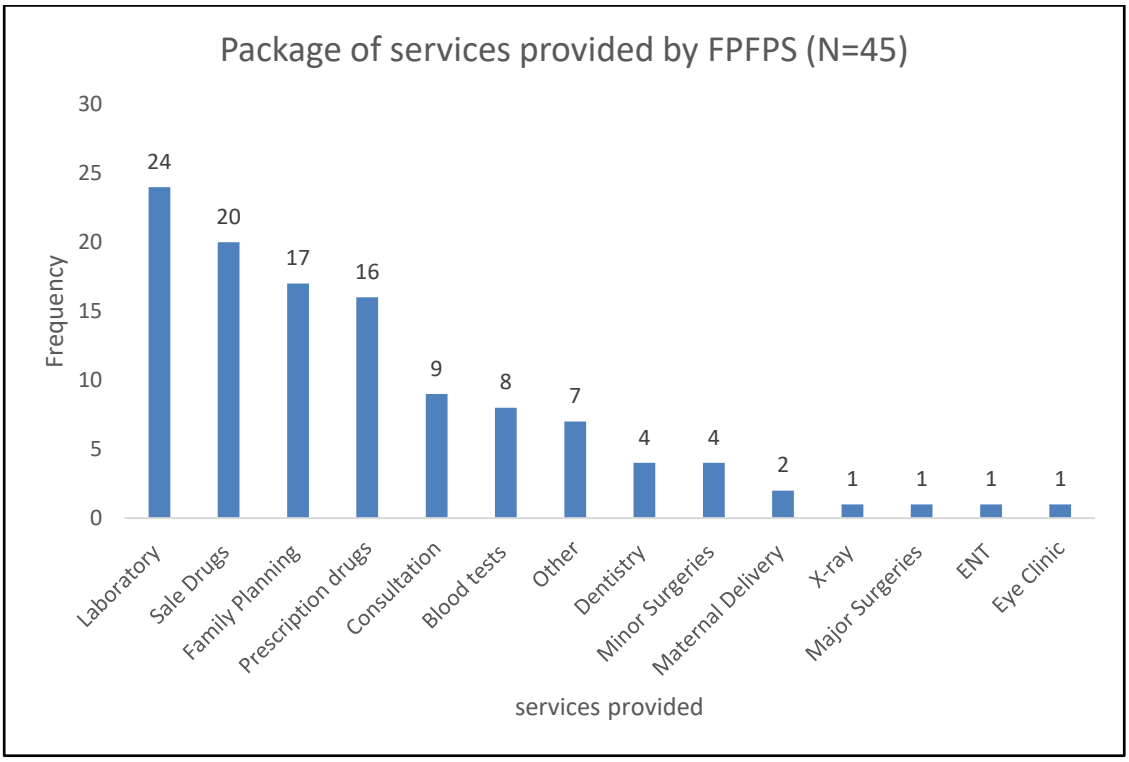
Source: Organisational survey

5.1.5. Package of services

The results revealed that FPFPs provided a range of services. As indicated in Figure 14, skill-demanding services such as maternal deliveries and major surgeries were offered by a few, which had the requisite medical equipment and personnel. For instance, in this respect, private hospitals and some relatively large medical centres had a competitive advantage. Few FPFPs offered specialised services, such as dental, ear, nose and throat (ENT) and X-ray services. In some cases, FPFPs specialised in certain services, for instance, stand-alone laboratories that specialised in haematology and urine tests, whereas other FPFPs were a one-stop centre for all services. For example, some clinics had a laboratory and mini pharmacy incorporated. This is one of the survival strategies revisited in Chapter 6. The 'other'

category included services such as Ante-natal clinic (ANC), paediatric services, HIV screening, scan, mammography and dermatology consultation.

Figure 14: Package of services provided by FPFPs in Gulu

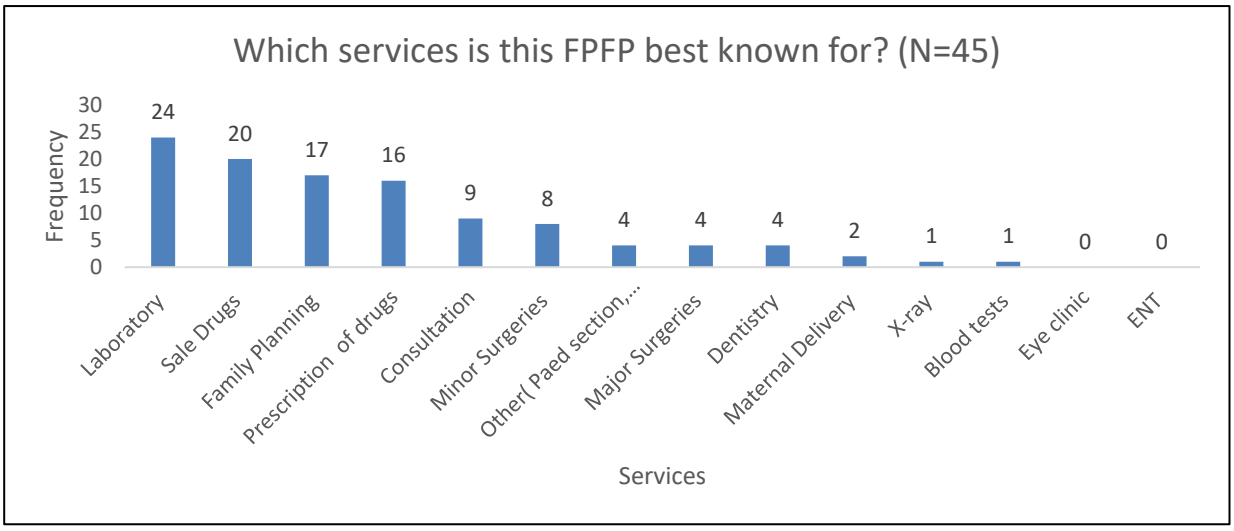


For which service is this facility best known?

Of the package they provided, the managers of FPFPs were also asked to report on the services offered by their facilities that the facilities were best known for or the services for which their loyal customers always came. Figure 15 shows that the majority of the FPFPs reported that they were 'best known' for laboratory services (25). However, only one FPFP, a stand-alone laboratory, stated that it was best known for 'blood tests. Few FPFPs reported being 'best known' for maternal deliveries. Similarly, only one FPFP reported being 'best known' for X-ray. Furthermore, many FPFs reported being 'best known' for the sale of drugs (20), family planning services, prescription of drugs and consultation.

Whereas a few had reported that they provided ENT-related services as well as an eye clinic[32], none of the FPFPs mentioned that they were best known for these afore mentioned services. Five of the FPFPS reported they were known for other services, particularly a paediatric section (1), HIV screening (1), scan (1), gynaecology (1) and mammography (1)). Having a paediatric section was reported by only one clinic (one of the old); only the private hospital mentioned mammography.

Figure 15: Which services is this FPFP best known for?



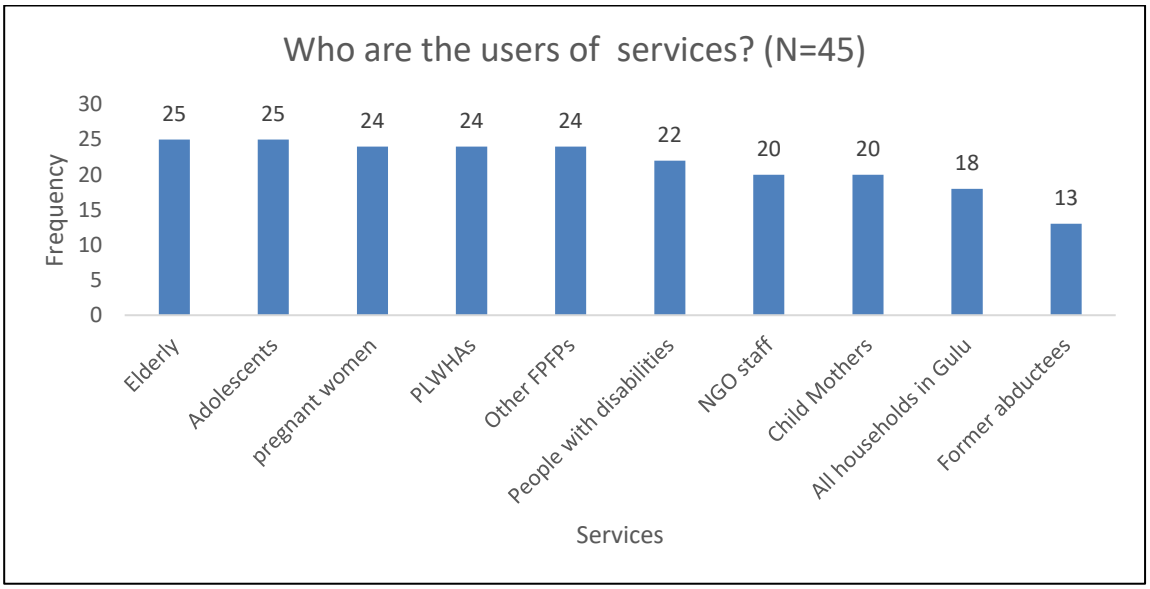
Who are the users of the services in the FPFPs?

The survey questionnaire also had a question in relation to who the service users for the services provided by FPFPs were. The researcher had generated nine pre-determined categories, namely the elderly, people with disabilities (PWDs), pregnant women, NGO staff, all households in Gulu, former abductees, persons living with HIV/AIDS (PLWHAs) and child mothers, and the results showed no significant

[32] See graph (Figure 1) under section on package of services

differences across all categories. However, Figure 16 indicates that relatively fewer reported that they provided services to all households in Gulu (18) as well as former abductees (13). Some FPFPs reported that they provided services to all people(19), whereas three FPFPs reported that the users of their services were not necessarily people, rather other facilities, i.e. clinics(1), drug shops(1) and hospitals(1).

Figure 16: Who are the users of the services in FPFPs?



5.1.6. Human resources for health

Based on the survey findings, the private hospital had the highest number of staff (62), followed by medical centres and clinics, whereas the drug shops had the lowest number of staff (2). It is important to note that, in most cases, this total always included part-time staff (Figure 17). Part-time staff were common across all the FPFPs interviewed, with the clinics and drug shops more likely to employ such staff while laboratories were least likely. Concerning cadres, the commonest cadre employed by the FPFPs interviewed was enrolled nurses, whereas specialists, such as radiologists, surgeons and gynaecologists, were few (Figure 18).

Figure 17: Availability of part-time staff in FPFP facilities

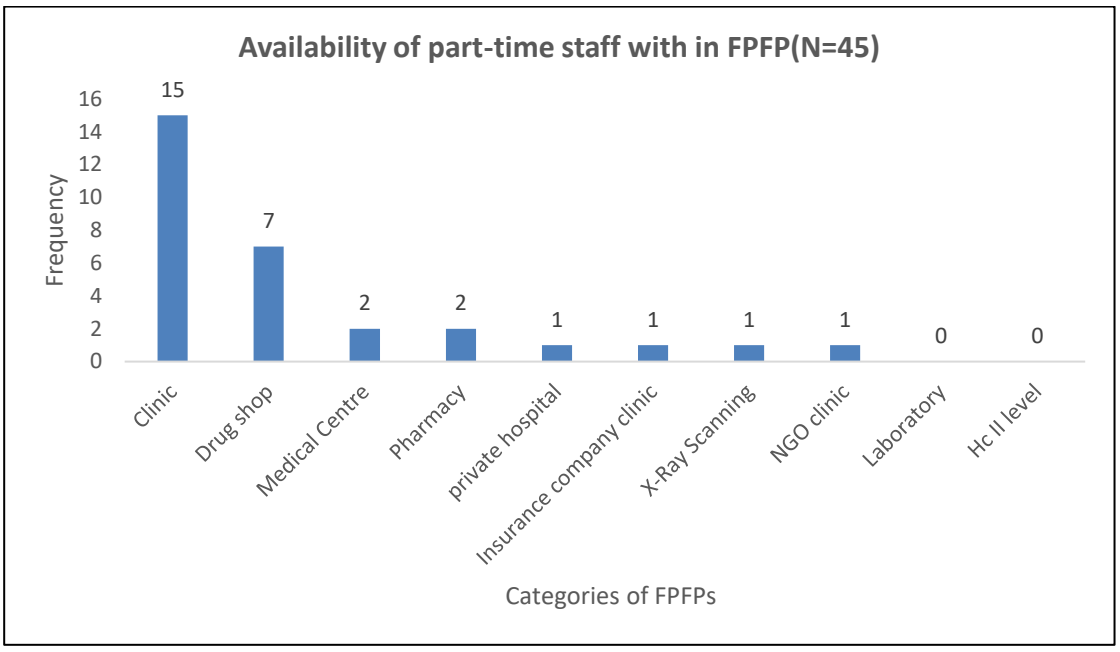
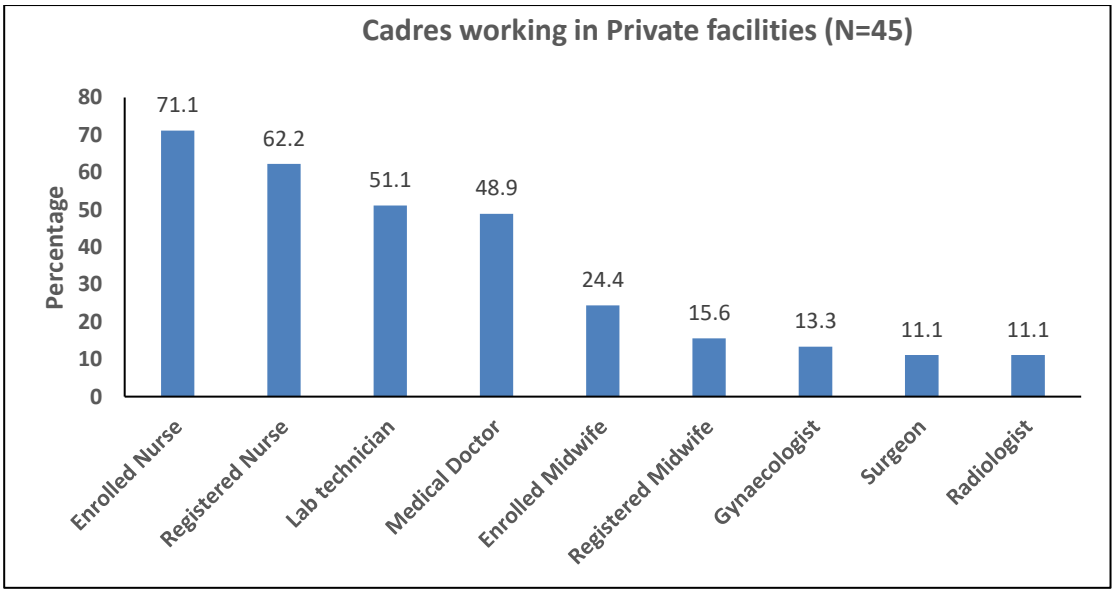


Figure 18: Cadres working in FPFPs



5.1.7. Admission capacity for FPFPs in Gulu

The researcher assessed the admission capacity of the FPFPs in Gulu based on the reported bed capacity/number of beds in the facilities/organisations. Table 16 shows

that only 15 of the 45 FPFPs reported that they had beds. The private hospital had the highest number of beds, followed by a medical centre and some clinics. The pharmacies, drug shops as well as the laboratories, the insurance company clinic and the NGO clinic all reported that they did not have beds for admitting patients.

Table 16: Number of beds reported per category of FPFP

Status of admission	Category of organisation	Number of beds for admission			
Admit		**1-6 beds**	**7-15 beds**	**50 beds and above**	**TOTAL**
	Clinic	6	1	1	8
	Medical centre	3	2	0	5
	Private hospital	0	0	1	1
Not admit	Pharmacy	0	0	0	0
	Insurance company clinic	0	0	0	0
	NGO clinic	0	1	0	1
	Drug shop	0	0	0	0
	HC II	0	0	0	0
	X-ray and scan centre	0	0	0	0
	TOTAL	**9**	**4**	**2**	**15**

Source: organisational survey

5.1.8. Days open in a week and operating hours

Figure 19 shows that the majority of the FPFPs (77%) reported that they were open for business every day of the week, including weekends, while a few were open during weekdays only. Figure 20 illustrates that the majority of the FPFPs surveyed reported being open for 12 hours a day, while a few operated for 24 hours.

Figure 19: Number of days open in a week

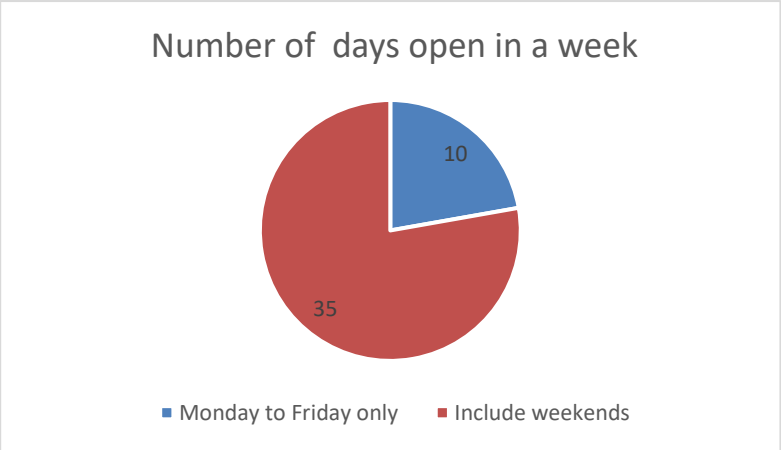
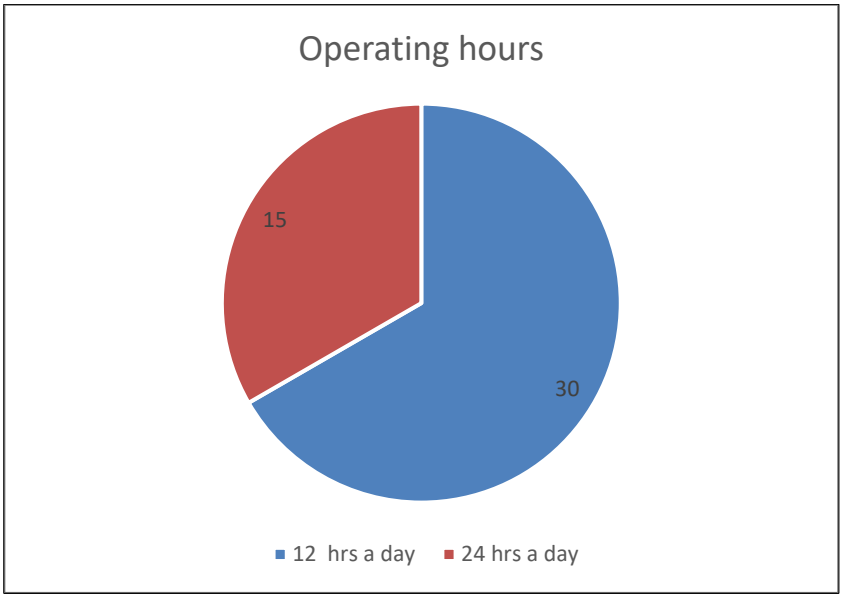


Figure 20: Operating hours for FPFPS



5.2 How the FPFP Sector in Gulu Has Evolved Over Time

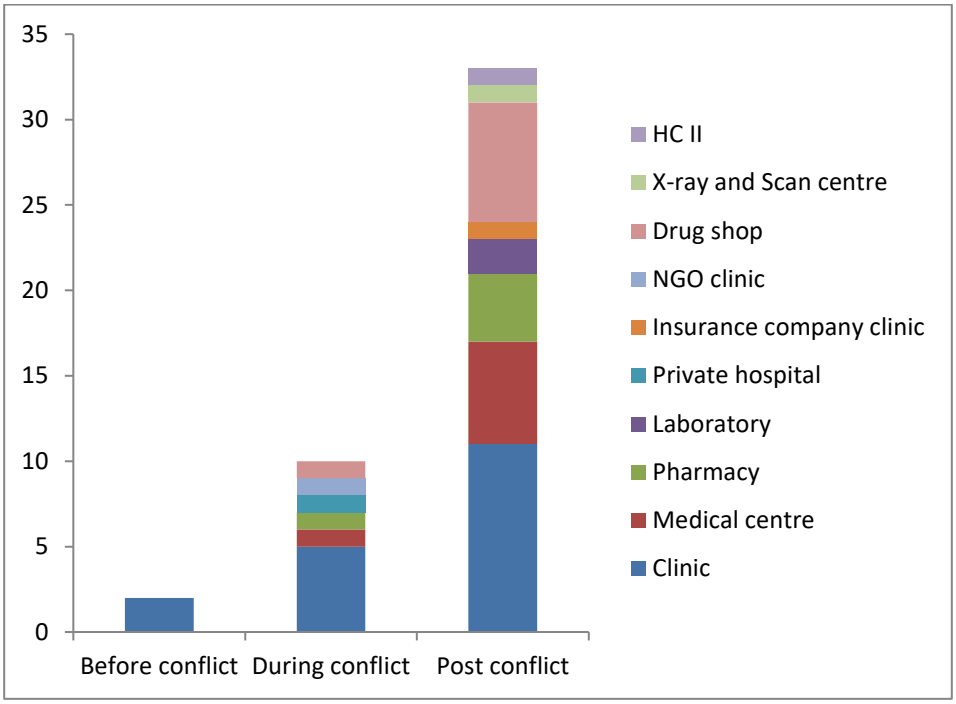
The survey data was used to understand how FPFPs evolved in general as a collective group, whereas life histories (timelines) were used to map the changes that occurred in the 'lives' of the businesses during and after conflict.

The FPFPs experienced various dimensions of growth, either collectively or individually. The key informant interviews provided further insights into the general increase in number. The most prominent dimension of change related to an increase in the number of FPFPs in the area/district. The dimensions of growth (changes) in the life cycle of the individual businesses from life histories are described later on.

5.2.1 Increase in number of FPFP across conflict periods

As might be expected, the quantitative findings of the organisational survey showed that the number of FPFPs established within Gulu municipality increased from 2, 10 and 33 across the pre-conflict, conflict and post-conflict periods, respectively. As a category, clinics dominated the period before the conflict, and they continue to be higher in number compared to other FPFP categories both during and after conflict. In the post-conflict period, new types of FPFPs emerged, such as insurance company clinics, stand-alone X-ray, and medical imaging centres and stand-alone clinical laboratories. Figure 21 illustrates the variation of FPFPs across phases of conflict, namely before during and after conflict. Notably, the details reflected in Figure 21 rely heavily on those interviewed in the survey and are computed using the year of establishment as indicated for each of the FPFPs within the survey. Therefore, the specifics of pre-conflict and conflict periods may have been different from what was reported.

Figure 21: Number of FPFPs established during and after the conflict

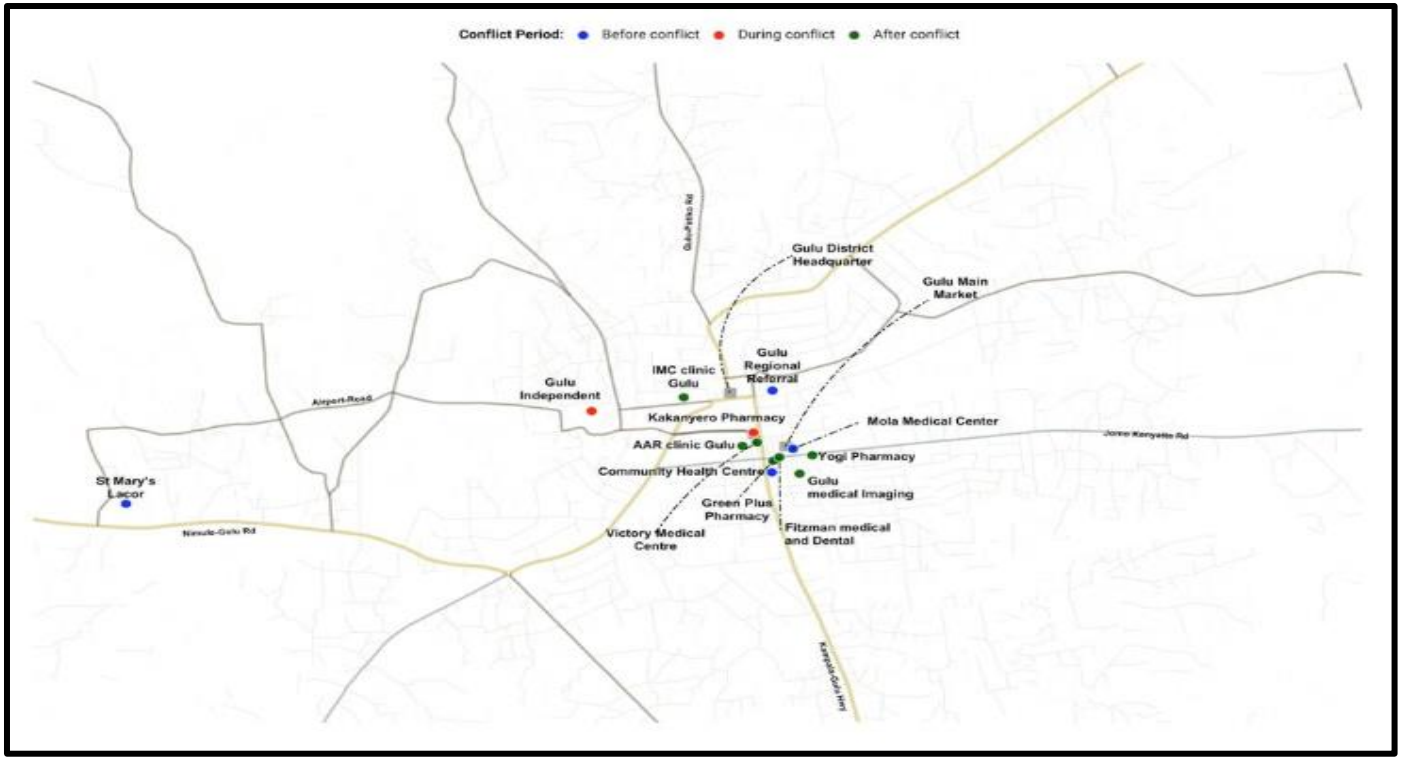


The general impression among those who participated in the in-depth interviews was that the FPFPs were few during the conflict compared to the post-conflict period. This could also explain why most of the respondents even went further and listed some older FPFPs by name. This opinion is illustrated by a health worker who had over 10 years' experience working in the area.

> [the clinics increased in numbers] because, for example in Gulu, during the war, I can count. We had Mola medical clinic, Lacekocot clinic, Gulu community medical clinic, I think those were the main clinics or common ones by that time […] but now everywhere! […] you walk across every street you find a pharmacy. […] more than one so the number is big. (P4: KI_ Healthworker_Other FPFP Facility)

Furthermore, regulators also reported that FPFPs increased in number over time both in Gulu municipality and within the region and that the increase had been observed with respect to drug shops, clinics and pharmacies.

Figure 22: Illustration of regulator's recollections about how the sector has grown over time



[…] the number of drug shops in the municipality is now […] over 60! (P9: KI_ Regulator_ District level)

[…] in 2012 the number of licensed clinics was 40 in northern Uganda. In 2013 it was 54 clinics and in 2014 it was 60[…]. (P 8: KI_ Regulator_ District Level)

One of the regulators attempted to illustrate his recollection using a hand drawing to provide an impression of which FPFPs existed before, during and after the conflict. Figure 22 shows the modified version of the original drawing, which was modified with longitude and latitude co-ordinates, and then reconstructed using the Mapping and Geographic Information System (GIS).

Source: Regulator's recollections

5.2.2 Reasons for the emergence and increase in number of FPFP sub-sector in Gulu

The emergence of the FPFPs in Gulu and the increase in their number in the post-conflict period were attributed to several factors. These include the return of peace; the increase in population and perceived willing to pay; the demand for specialised services; inconveniences associated with public and PNFP facilities increased demand for drug procurement; and systemic health workforce challenges in the public sector.

Return of peace

The return of peace to Northern Uganda after 26 years created a favourable operating climate/environment for businesses, including the health service providers.

> I think they [private for-profit providers] have changed in number and quality, the numbers are increasing, and the quality is also improving. […] on one side I think there is the return of peace, so health service providers feel confident to come. (P6: KI_ Manager PNFP Facility)

Increase in population and perceived willingness to pay

The influx of people to Gulu town from villages in search of safe places to live during the war was reported to have [cumulatively] resulted in the increase in population. In contrast with what would have been expected, after the conflict, many of the people never returned to their original villages, instead preferring to remain in the slum areas of Gulu town. To some respondents, the increase in population implied an increase in aggregate demand for healthcare services, which had reportedly overwhelmed other providers in terms of capacity. As indicated by a manager of a medical centre, FPFPs took advantage of the available demand.

> I think Gulu was growing bigger in terms of population, the needs for healthcare were also required, and […] the war was also raging. […] with villages mostly affected. But the town was better and safer and so more people were accommodated in town, so there was a need for healthcare. (P18: LH_Medical centre_ Old FPFP)

The increase in the number of NGOs, banks and supermarkets (such as the now-closed Uchumi outlet) created a perceived increase in income and willingness to pay for services, particularly those managed by the facility-based insurance companies with clinics as well as those without clinics. A case in point is P15, an insurance which opened in 2010 to address the health demands of employees of the many NGOs operating in the area at the time.

> […] Basically [P15] came to Gulu in 2010 based on many NGOs that were [still] working here due to the conflict […] and I think they [managers of insurance company clinics] saw that as an opportunity to open up in Gulu. (P15: LH _Insurance Clinic_ Young FPFP)

Demand for specialised services

In some cases, corporate clients being catered for by insurance companies reflected the demand for specialised services because of the willingness to pay and the other providers did not have the capacity to provide such services at the time. For P20, a stand-alone clinical laboratory, the limitation of the available providers to offer certain specialised services created a vacuum as well as an opportunity to set up shop.

> […] they opted to start the Clinical Independent Laboratory because in Northern Uganda, apart from XX [a named Clinical Research Centre] which was in Eastern, there was no laboratory which could help [with] diagnosis of other infectious diseases. They also came to conduct some complicated tests, which cannot be handled by either the PNFP hospital and the government hospital or those that the other health facilities are not doing. […] Under dermatology we have series of tests those that are complicated […], for example in relation to the fertility tests related to checking hormones […] even the PNFP hospital has just recently started offering it but it was not offered before. (P20: LH_ Clinical Lab_ Young FPFP)

Inconveniences associated with public and PNFP facilities

The inconveniences associated with alternative providers, such as PNFP or public facilities, and the absence of the private sector during the conflict period motivated

an increase in the establishment of FPFPs in Gulu. The associated costs were related to either time or prices. For instance, long queues in the outpatient departments as well as the long time spent waiting to receive lab results or X-ray reports in PNFPs or public facilities were reported as inconveniences. The time taken to access X-ray and laboratory test results in the existing PNFPs and public facilities was also perceived to be long and this created a gap, which was readily filled by owners of one of the stand-alone laboratories and an X-ray imaging centre. These facilities noted that they could provide the same services at competitive prices in a shorter time. Key informant interviews also indicated that FPFPs were preferred because they were perceived to be more convenient owing to shorter queues compared to the public and PNFP facilities that offered free services.

> […] the PNFP hospital here has all the equipment they need but they were overwhelmed […] too much work because it is private not-for-profit, and it offers free services. Therefore, everybody ends up there. So when you are requested to go there [PNFP hospital] and have an X-ray taken, it would take you an average of three days if your condition is so severe and you might not survive the time for the results. Then, in the private hospital, they had the service, but the costs were expensive to the community. (P19: LH_ X-ray centre_ Young FPFP)

> […] the biggest advantage of private for-profit to a patient is convenience. […] usually, you do not find a long line. So, you are attended to quickly […] (P2: KI Manager_Public Facility)

The increased demand for drug procurement

The increase in the number of pharmacies was associated with the increase in the number of other facilities/categories that relied on drugs for treatment and competition in other markets. The increased numbers of pharmacies in Kampala threatened their survival, causing some of them to not only look for viable markets elsewhere (such as in Gulu) but also to innovate ways of beating competition in Gulu. Examples of

these innovations are those around the transportation of drugs to Gulu, something that used not to happen before. One of the managers of the PNFP hospital remarked on how they had benefited from these innovations.

> I think these pharmacies that have opened here [in Gulu] due to competition from Kampala. The competition there is pushing them to bring services nearer from Kampala. Previously, we had to transport drugs from Kampala ourselves. Therefore, they tried to take advantage over the others, by saying, if you buy from us, we offer free transport. Now if you order from Kampala the lorry will just deposit it here [in Gulu]. For us, we save transport sending our Lorries to Kampala. […] you order, and they deliver it here. Therefore, probably it is the competition that is -between the pharmacies which sell those drugs. (P6: KI_ Manager_PNFP Facility)

These innovations in drug procurement in the private sector mimic the public sector intervention of the last mile delivery (LMD). The last mile delivery is an intervention in the supply chain management of drugs which enables the National Medical Stores (NMS) to deliver medicines to the doorstep of every health facility countrywide[33]. The LMD intervention has been prioritized to enhance reduction of stockout challenges in the public sector in Uganda(MOH., 2014)

Systemic health workforce challenges for the public sector

Two systemic health workforce challenges experienced by the public sector, namely poor remuneration and inadequate absorption of cadres into the labour market, created an opportunity for the FPFPs. For instance, interviews with some FPFPs revealed that inadequate incentives, particularly lack of adequate salaries in the public sector, contributed to an increase in numbers of FPFPs. Many of the owners opened FPFPs as a side business to enable them to earn an extra income and be

[33] National Medical Stores. https://www.nms.go.ug/index.php/client-services/last-mile-delivery-lmd

able to support their families. Hence the establishment of FPFP businesses represented an opportunity for some health workers.

> We [me and my wife] were working together in Gulu regional referral hospital. She is a nurse and I am a Principal Human Anesthetist. So, when we thought of starting this clinic […] because we wanted to have some supplement to our earning since we have family responsibility. (P17: Community Clinic_ Old FPFP)

> […] I do not think the market has anything to do with it but the other reason I would say is that the government institutions are now not giving the kinds of incentives that people would really want. Therefore, other medical practitioners are now finding that it is better to put a clinic somewhere they can get some survival out of it. […] so, it is side business for survival. (P4: KI_ Health worker_ Other FPFP Facility)

According to key informants in the PNFP sector and some regulators, there was a surplus of health workers in the market post-conflict. They attributed the surplus to the increasing outputs from health training institutions located in Gulu town, their poor absorption into the healthcare system and the return of health workers who had fled from the area during the conflict. This availability of the surplus of health workers created an opportunity for FPFPs to increase in number. In the absence of obvious employment related to their field, health workers found it easier to open health-related businesses and ultimately contributed to the increase in the numbers FPFPs in Gulu municipality.

> […] many clinical officers have been *produced* in Gulu. There are two health training schools in Gulu, and the government is not taking them, so they are available, looking for anything to do. (P6: KI_ Manager_PNFP Facility)

> […] during the time of the war most of the qualified staff were not within the district and [now] people have returned, and they want to settle down. (P9: KI_ Regulator_ District level)

Weaknesses in regulation and enforcement about opening and operation of FPFPs

Weaknesses in the supervision and enforcement of policy requirements for opening certain categories of FPFPs also created opportunities for FPFPs to open in Gulu, post-conflict. However, the key informants were divided regarding this finding. The district-level regulators in the DHO's office[34] reported that during conflict, regulation was stricter in relation to the opening of new FPFPs within Gulu municipality, given that each category of organisation could only be established/started by the cadres that possessed professional skills related to that category. For instance, only pharmacists could establish/start pharmacies. In contrast, there was a perceived flexibility in regulating and enforcing the opening of FPFPs post-conflict and this was indicated in the interviews, which showed that the majority of the owners did not have the relevant qualifications but, instead, had a contract with a qualified cadre whose job was to 'supervise' the particular FPFP. It was the supervisor's licence that would be revoked in case of any misconduct. This was the case with many clinics and pharmacies that were opened post-conflict.

> During the war, they [FPFPs] were fewer. […] I think it was because of policy. […] they were only allowing doctors mainly to open clinics but now the policy changed now. Clinical officers, nurses even can now open clinics, so the issue was about policy so you find that they were fewer during the times of the war and then as now that the war is over, the clinics and drug shops are increasing in number. (P4: KI_ Health worker_ Other FPFP Facility)

> [Unlike now], during the war a nurse could not open a clinic. (P9: KI_ Regulator_ District level)

[34] The researcher was unable to collect information about changes in the regulation of the FPFPs by the professional bodies during and after conflict.

However, one of the participants stated that the enforcement of policy/regulation during the conflict was weak and attributed this to the existence of limited supervision because of conflict, which ostensibly created room for quack doctors to open clinics. The regulators also agreed that the security situation during conflict made follow-up and support supervision more difficult for them. Nevertheless, although support supervision was reported to be more common in the post-conflict period, frequency of the visits was reported to be limited owing to lack of funding for transport as well as larger coverage areas.

> [the FPFPs have] drastically increased [in numbers] due to lack of supervision. The law was not being enforced. All the supervisors were at ministry of health [head offices located Kampala]! (P8: KI_ Regulator_ District level)

In addition to lack of facilitation for transport, other challenges experienced by regulators at district level, which were peculiar to the post-conflict period, included death threats (security concerns) and understaffing, given that some regulators held other positions within the district health office.

In relation to professional bodies, all the respondents reported a limitation in scope of coverage. Out of the four professional bodies, the researcher observed that only one professional body – Allied Health – had a coordinator with an office at the Gulu district health headquarters in Gulu. Nevertheless, he reported the issue of a heavy workload, given that he also acted as a regional coordinator. Whereas other professional bodies noted that they were partners with the district office in their regulatory role in the FPFPs, they were limited in scope of coverage, given that they were based in Kampala and made only a limited number of trips to Gulu. At the time of data collection, the Uganda Medical and Dental Practitioners' Council (UMDPC)

was in the process of introducing the involvement of retired health workers in the supervision of FPFPs located in their areas. This was expected to address the issue of the high cost of support supervision.

5.2.3. Characteristics and evolution of 10 FPFPs under in-depth study (general life cycle curves)

Introduction

This section presents findings about the 10 FPFPs which acted as sub-units of the study. The section largely draws upon life-history interviews. The researcher first presents a table of characteristics of all the 10 FPFPs. This is followed by a presentation of critical events in the evolution of the 10 FPFPs across conflict periods and then an analysis of the dimensions of growth as reported by the FPFPs across the same periods. The findings show that the post-conflict period was perceived to be better than the conflict period, with the former presenting more opportunities to navigate and to experience various dimensions of growth. Nonetheless, numerous challenges were also experienced.

Characteristics of the 10 FPFPs for in-depth study

Table 17 summarises the characteristics of the 10 FPFPs that participated in the in-depth study using life histories, Five of the FPFPs had been in business for over 10 years, and two had been established before the war. However, the other five FPFPs were established after the war. Three of the 10 FPFPs were set up using family savings, four using individual savings while three were set up using savings by groups of individuals and were, therefore, group owned. Five of the 10 FPFPs provided a

wide package of services, with three specialising in the sale of drugs, one specialising in X-ray and imaging and one specialising in laboratory tests. The highest number of staff among the 10 FPFPs was 62 health workers while the lowest was two. Only two of the FPFPs had bed capacity, six did not have any bed capacity and one did not provide information about their bed capacity. All the 10 FPFPs are open for business every weekday, and only one opens on weekends. Seven of the 10 FPFPs open for 12 hours a day while three open for 24 hours.

Table 17: General descriptive characteristics of FPFPs under in-depth study

	Facility ID and category	Characteristics for FPFPs under in-depth study						
		Age of existence (in years/months)	Year of initial registration	Ownership and source of capital	Package of services	HR staffing	Bed capacity	Opening days and hours
1	P17 Community health centre	30	1985	Family	Sale of drugs, prescription, family planning services, minor surgeries, blood tests, lab services	12 (4 nurses, 3 lab techs, 1 anesthetic, 2 registered nurses	unknown	Every weekday, 12 hrs.
2	P18 Medical centre	20	1995	Individual	Medical consultation, lab services, radiology/X-ray. Ultrasound scan, immunisation, physiotherapy. 24hr nursing care, maternity, free counselling, minor surgery, dental services, bedside services, medical camps (quarterly) outreach, ART(HIV) testing and drugs etc.	19(includes part-timers- specialists and clinical officers) and 5 cleaners	20	Every weekday 24 hrs.
3	P14 Pharmacy	18	1997	Family	Sale of drugs, prescription of drugs	5	N/A	Mon-Saturday for 12 hrs.
4	P23 Drug shop	14,3mths	2002	Family	Sale of drugs	2	N/A	Every weekday for 12 hrs.
5	P22 Private hospital	13	2002	Group of individuals	Dentistry, consultation, prescription, maternal deliveries, major and minor surgeries, blood tests, gynaecology services, mammography	About 62	68 beds	Whole week including weekends, 24 hrs
6	P21 Clinic	7	2009	Individual	Dentistry, family planning, minor surgeries etc.	12 staff (4 co, 3 lab tech, 2 nurses, 1 reg nurse, 1 nursing assistant, 1 doctor		Every weekday, 24 hrs. every
7	P15 Insurance company clinic	6	2009	Group	Dentistry, consultation, prescription, minor surgeries, blood tests, ENT, laboratory services, ANC	11	N/A	Every weekday for 12 hrs.
8	P20 Clinical lab	6	2009	Group	Laboratory services only	5 staff (2 lab tech, 2 lab technologists, 1receptionist	N/A	Every weekday for 12 hrs.
9	P16 Drug shop	2,6mths	2011	Individual	Sale of drugs	2	N/A	Every weekday 12 hrs.
10	P19 Imaging centre	2,4mths	2012	Individual	X-ray and scanning services	4(1 radiologist, registered nurse, and 2 cleaners)	N/A	Every weekday. 12hrs

Source: Organisational survey and timelines

General evolution of the FPFPs

The life histories of the FPFPs indicated that they experienced various events which affected their life cycles, and these are summarised in Table 18. The researcher used Table 18 as a basis to generate Figure 23. The events shaded in grey in Table 18 indicate the times when the businesses experienced a plunge in their growth. For example, those that changed location experienced a reduction in the number of customers, given that not all loyal customers had got to know about their move. Contemplating closure and temporary closure were critical events which created negative progress in the evolution of the FPFPs.

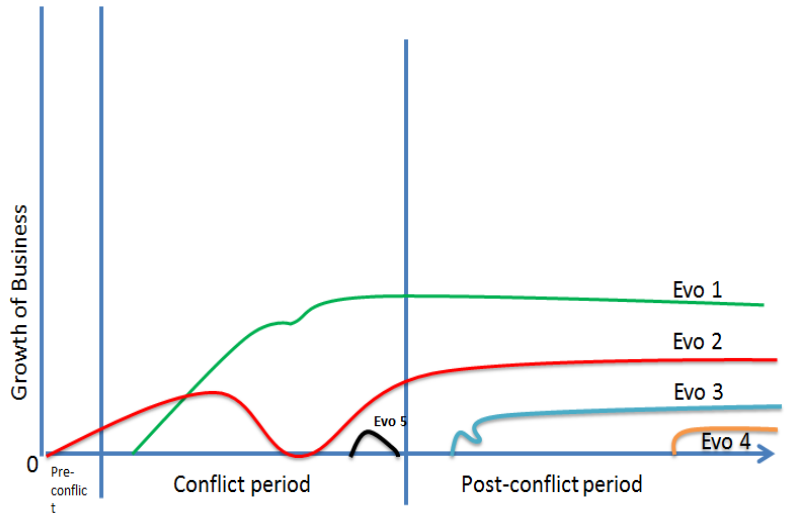
Table 18: Summary of major events in the 'life' of 10 FPFPs for in-depth study across three conflict periods

	Event	Before war	During war	After war	TOTAL of events
1	Establishment	2	3	5	10
2	Date of initial registration (at the start of business)	1	4	5	10
3	Change of location	1	2	2	5
4	Change of name	-	1	-	-
5	Stopped renting	-	2	1	3
6	Upgraded from small to big category	-	1	5	6
7	Closed temporarily	-	2	-	2
8	Contemplated to close	-	-	1	1
8	Expanded in size of building	-	-	6	6
9	Started partnership with the district for services and training	-	1	3	4
10	Started partnership with NGOs and/or insurance companies	-	-	5	5
11	Increased number of staff	-	1	3	4
12	Increased number of clients	-	-	5	5
13	New services	-	-	5	5
14	Loss of qualified staff (specialists)	-	-	4	4
15	Opened up braches outside Gulu	-	-	2	1
16	Stopped sharing space with another	-	-	1	1
17	Reduced number of clients	-	1	4	5
18	Started conducting medical camps	-	-	2	2
	Total count	**3**	**16**	**58**	**76**

Source: Organisational life histories

The FPFPs were at various stages of growth; some were already mature; others were still relatively young and being established. However, the researcher chose to divide them into two categories of young and old. Furthermore, the stages of the growth of the businesses did not follow the typical life cycle, namely birth, early growth of business, subsequent growth, survival/stagnation and death[35] (Lester et al., 2003) in a linear manner. Growth sometimes happened in inverse order. For example, an organisation was established, closed/died shortly after, and then was revived. An organisations' growth stage overlapped with the survival stage and it was difficult to separate them in the write-up; this was true of the growth and survival stages. Figure 23 represents the researcher's attempt to illustrate the overlaps.

Figure 23: Evolution of FPFPs across conflict periods



Key

Green: Established during conflict, had some challenges but survived and are still existing

Red: Established pre-conflict, temporarily closed and then re-emerged, still existing

Blue: Established post-conflict, had some challenges in the beginning, still surviving

Orange: Established post-conflict, still in initial stages, surviving

Black: Established during conflict and died as soon as established

Source: Constructed by researcher based on life histories and events in table 18

[35] The researcher was unable to talk to managers of the FPFPs that had closed business(died) but obtained this information from some managers of those that were open.

Presentation of timelines for some FPFPs for in-depth study reconstructed based on life histories

The researcher reconstructed a timeline for each of the 10 FPFPs which participated in the life-history interviews. The researcher randomly selected four of the 10 timelines – P18 (Figure 24), P14 (Figure 25), P22 (Figure 26), P19 (Figure 27) – to present as raw data while the rest of the six timelines – P15 (Appendix 12), P16(Appendix 13), P17(Appendix 14), P20(Appendix 15) and P21(Appendix 16) and P23(Appendix 17) – have been attached as appendices. P stands for participant identification while the number in roman numerals was automatically assigned in ATLAS.ti software during the process of filing interviews. In the write-up, the researcher selected examples of timelines that were representative of the growth dimensions being described. The selection of the timeline was informed by the extent to which an FPFP reported experiencing a growth dimension, as summarised in Table 19.

Figure 24: Timeline for P18

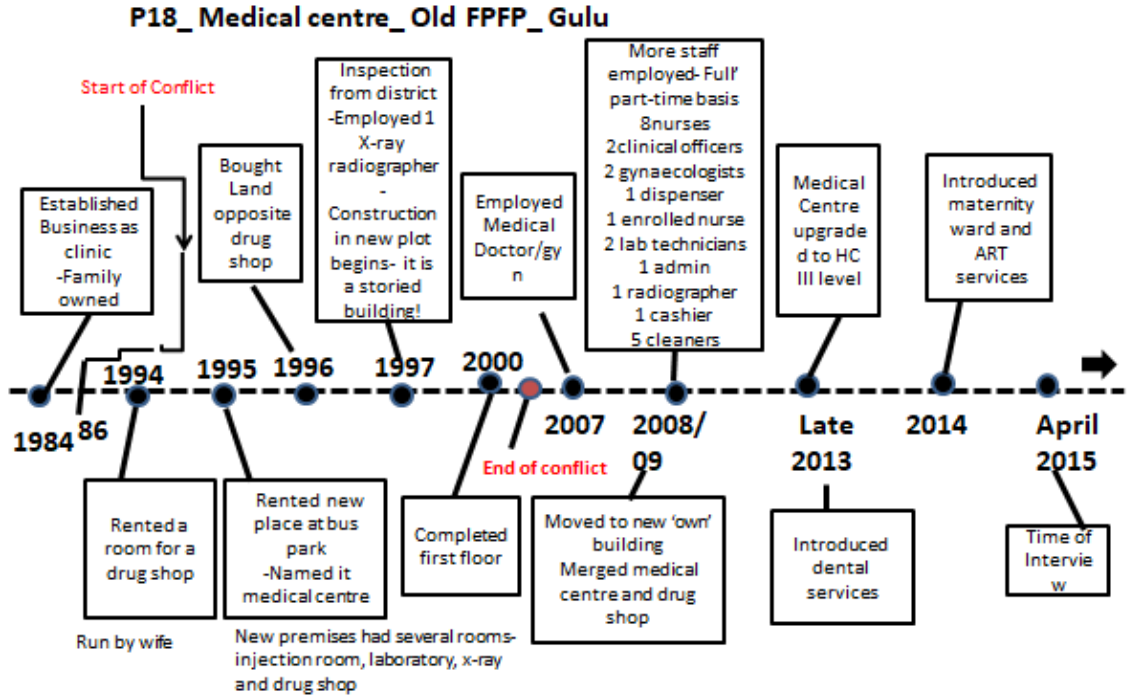


Figure 25: Timeline for P14

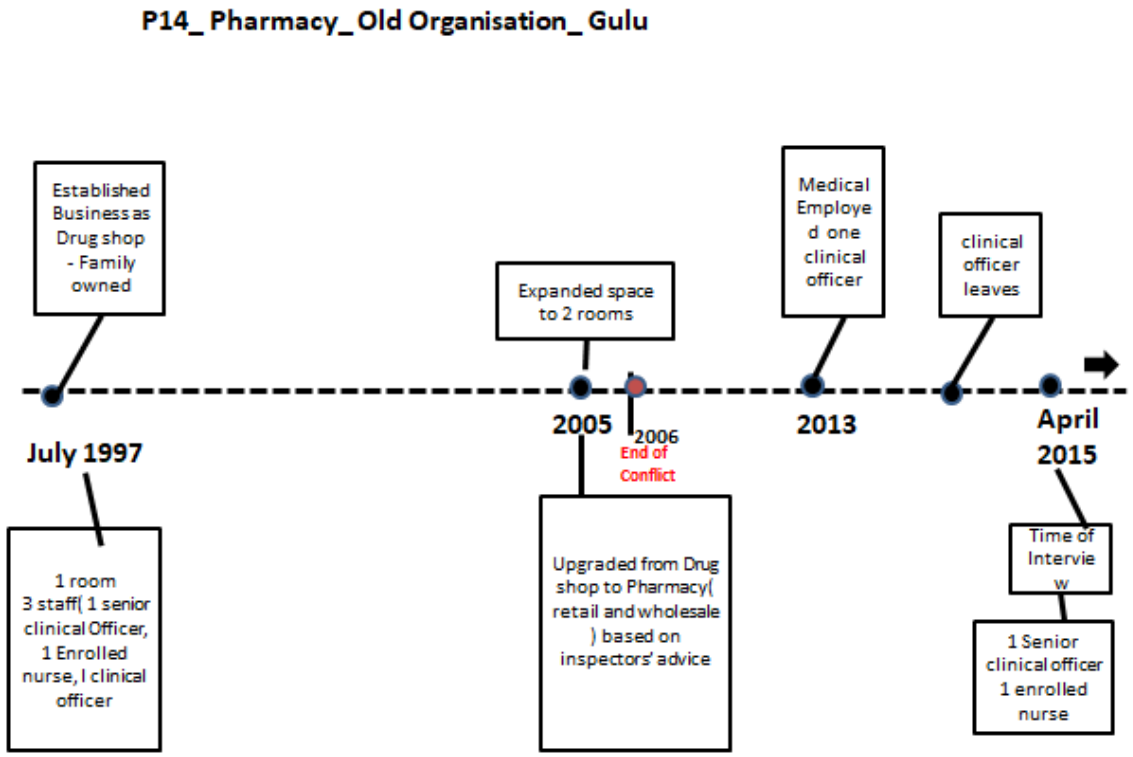


Figure 26: Timeline for P22

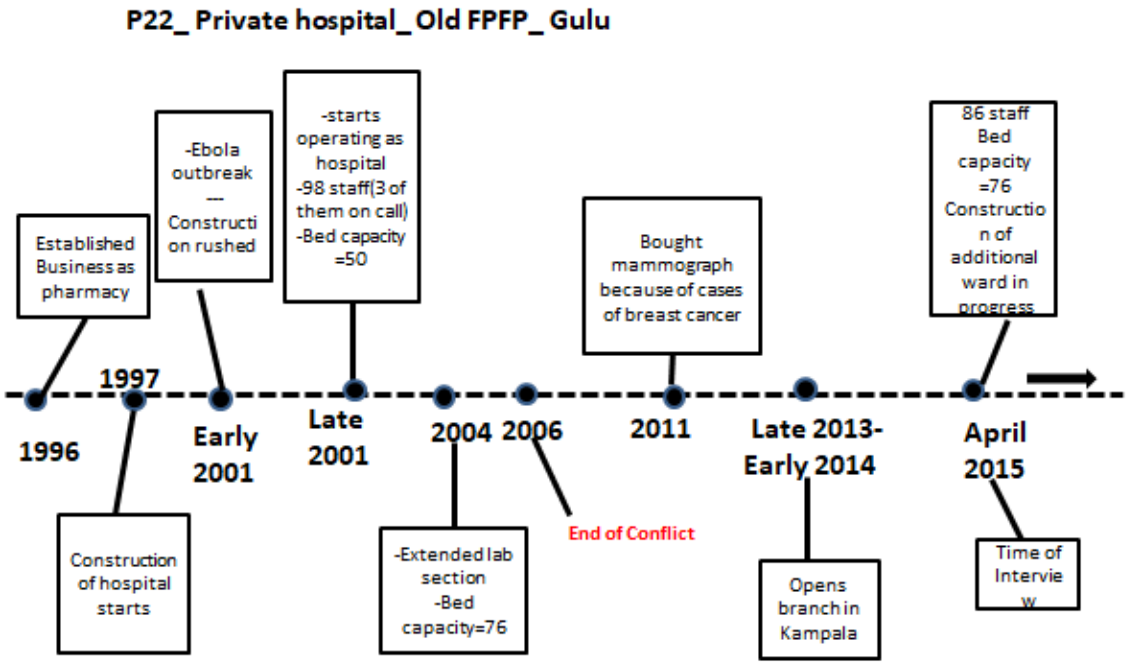
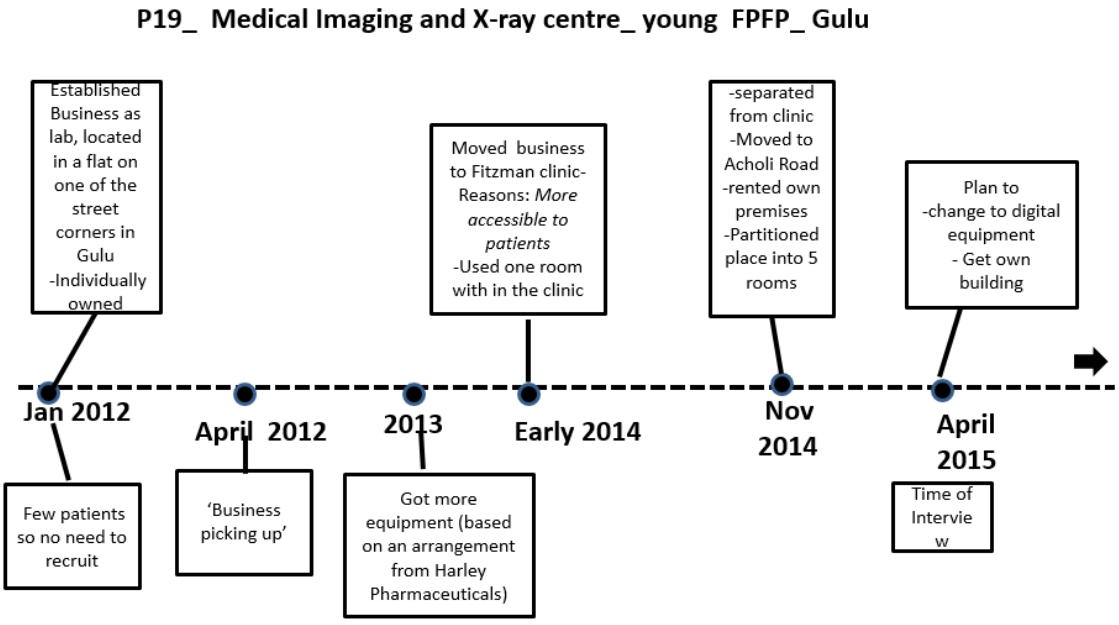


Figure 27: Timeline for P19



5.2.3 Common growth dimensions within FPFPs across conflict phases

Table 19 shows a summary analysis of the several developments/growth dimensions across the 10 FPFPs which participated in the in-depth study (life-history interviews). The FPFPs are arranged in descending order from oldest to youngest. Table 19 further shows that the FPFPs experienced developments around human resources for health, admission capacity, expansion of service package, infrastructural development, business expansion as well as upgrade, and these are then described with examples of timelines.

Table 19: Common dimensions of growth along the lifetime of FPFPs in Gulu

Facility	Age (in years/months)	Growth dimensions						
		Human resources for health	Bed capacity	Package of services	Infrastructure and space	Equipment	Opened branches beyond Gulu	Upgraded to a larger category
P17 Comm. health centre	30	+++	++	++	++	-	-	-
P18 medical centre	20	+++	+++	+++	+++	+	+++	-
P14 Pharmacy	18	++	-		+	-	-	+
P23 Drug shop	14,3 months	+	-	-	-	-	-	-
P22 Private hospital	13	+++	+++	+	+++	+++	+++	+
P21 Clinic	7	++	-	++	+	-	-	-
P15 Insurance company clinic	6	++	++	++	++	+	-	-
P20 Clinical lab	6	+	-	-	+	-	-	-
P16 Drug shop	2, 6 months	+	-	-	-	-	-	-
P19 Imaging centre	2, 4 months	-	-	-	++	+++	-	-

Source: Organisational life histories: Key: +++ high, ++ moderate, + low and – non-occurrence

5.2.3.1. Increase in the number of staff

Across their organisational life, FPFPs reported an increase in staff. However, this dimension of growth was more common among the older and larger FPFP organisations compared to the smaller and relatively new FPFPs. The increment in the number of staff was gradual rather than spontaneous, except in cases where one FPFP realised that they needed to hire a certain cadre(s) to fulfil the objective of expansion of service coverage for services for which their clients expressed demand. For example, P17(Appendix 14), P18 (Figure 24) and P21(Appendix 16) experienced an increase in staffing although P21 reported more struggles in relation to maintaining staff over the five years leading to the interview. P17(Appendix 14), a clinic, also reported an increase in the number of staff from seven (at the beginning) to 12 by the time of interview, whereas for P15 (Appendix 12), the number of staff increased from 10 to 20. Given that some of these staff were part-time, it was difficult to ascertain how many exactly were added at a given time. It was possible for the manager to add the part-timers to the other full-time staff working in that facility. The smaller FPFPs, such as P23 (Appendix 17) and P16 (Appendix 13), had an almost consistent number or a very slight increment in the number of staff. For instance, P23 (Appendix 17) relied heavily on close family members to run the business.

5.2.3.2. Increase in bed capacity

Larger FPFPs, for example P18 (Figure 24), P22 (Figure 26), and some clinics reported increased bed capacity, particularly those that provided admission services. By their very nature, some categories, for instance dug shops (P23 – Appendix 17) and P16(Appendix 13) and pharmacies (P14 – Figure 24) do not admit patients, hence they did not have any beds.

5.2.3.3. Expansion of service package

Some FPFPs, particularly clinics, medical centres, private hospitals and an insurance company clinic, reported an expansion of service packages along their lifetime. However, the degree to which some increased their service package varied, with more services added in the post-conflict period compared to during the conflict. Expansion of service package in the post-conflict period was influenced by factors such as the availability of demand for certain services, procurement of new machines/equipment, subsidies from the district, the need to have a competitive advantage over others/survive in the market.

For instance, many clinics reported having evolved from clinics without laboratories to clinics with laboratories to take advantage of the demand for diagnostic services, blood slides, pregnancy tests and sputum tests. For one insurance company, 'free' immunisation services did not exist until the district provided subsidies. P18 (Figure 24), a medical centre, introduced ART services owing to the existing demand from the HIV-affected population, particularly among the local *boda boda* (motorcycle taxi) riders.

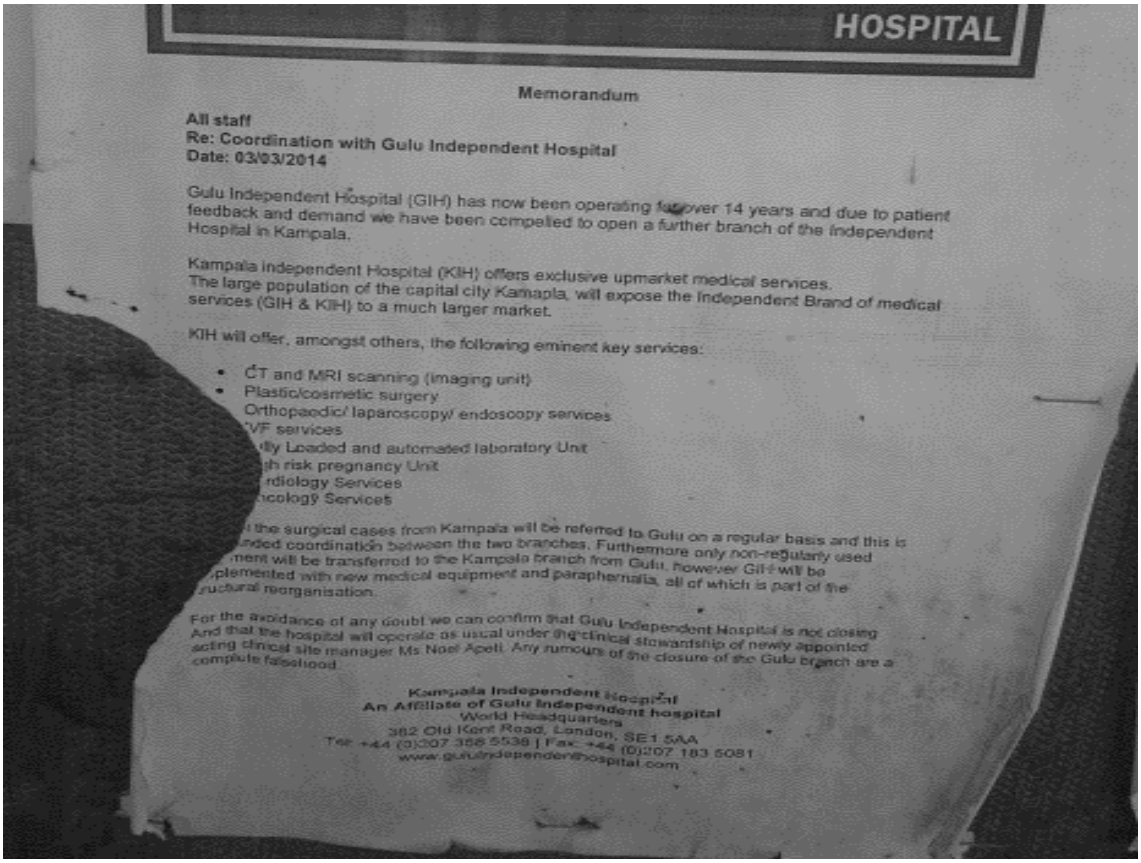
5.2.3.4. Expansion of infrastructure and space

Three FPFPs experienced expansion of infrastructure in the form of building extra rooms and finalization of structures whose construction had started earlier. These included P17(Appendix 14), P18(Figure 24) and P15 (Appendix 12). However, in the case of P20 (Appendix 15), the managers merely rented a place with more space rather than erecting a building on their own. Partitioning existing rooms was another perceived dimension of growth, which was reported as an enabler for expanding

operational space as well as the provision of extra services for P19 (Figure 27) and P16 (Appendix 16). For P19(Figure 27), the procurement of new equipment or machines constituted a form of expansion of infrastructure. In some FPFPs, expansion of infrastructure was perceived to signify improved capacity to provide new services which required more space and, ultimately, the expansion of the package of services.

5.2.3.5. Opening branches beyond Gulu

Two of the FPFPs reported that they had expanded their businesses by establishing branches within other areas beyond Gulu. A manager of P22 (Figure 26) attributed this change to patient *feedback* and *'expression of demand' for services of that FPFP in the 'new area'*. Indeed, based on observation, the researcher triangulated this finding. She observed three-quarters of an old notice pinned on the noticeboard (see Photo 2) communicating the change. The notice indicated that a new branch was opened in 2014 and this was mapped on the organisational timeline (Figure 26.) However, to appeal to the residents of the new area/town, the business had to adopt the name of the town. The notice indicated implications of the move: sharing some staff from the mother unit, unused equipment, and referrals for some major surgeries. A summary of the package of services provided was also indicated in the notice.


HOSPITAL

Memorandum

All staff
Re: Coordination with Gulu Independent Hospital
Date: 03/03/2014

Gulu Independent Hospital (GIH) has now been operating for over 14 years and due to patient feedback and demand we have been compelled to open a further branch of the Independent Hospital in Kampala.

Kampala independent Hospital (KIH) offers exclusive upmarket medical services. The large population of the capital city Kampala, will expose the Independent Brand of medical services (GIH & KIH) to a much larger market.

KIH will offer, amongst others, the following eminent key services:

- CT and MRI scanning (imaging unit)
- Plastic/cosmetic surgery
- Orthopaedic/ laparoscopy/ endoscopy services
- IVF services
- ...lly Loaded and automated laboratory Unit
- ...h risk pregnancy Unit
- ...rdiology Services
- ...ncology Services

...l the surgical cases from Kampala will be referred to Gulu on a regular basis and this is ...nded coordination between the two branches. Furthermore only non-regularly used ...ment will be transferred to the Kampala branch from Gulu, however GIH will be ...plemented with new medical equipment and paraphernalia, all of which is part of the ...uctural reorganisation.

For the avoidance of any doubt we can confirm that Gulu Independent Hospital is not closing And that the hospital will operate as usual under the clinical stewardship of newly appointed acting clinical site manager Ms Noel Apeli. Any rumours of the closure of the Gulu branch are a complete falsehood.

Kampala Independent Hospital
An Affiliate of Gulu Independent hospital
World Headquarters
362 Old Kent Road, London, SE1 5AA
Tel: +44 (0)207 358 5536 | Fax: +44 (0)207 183 5081
www.gulu...

Photo 2: Memo communicating opening of a branch beyond Gulu. Courtesy of Justine Namakula

5.2.3.6. Upgrade to a larger category

During their lifetime, some FPFPs reported an upgrade into a larger category from what they were at the start of business. For instance, one private hospital (P22) started as a pharmacy and later became a hospital because the owner thought a hospital could serve more people affected by the war. Another upgrade was that of a pharmacy (P14) which had started as a drug shop. In the case of the pharmacy, an upgrade was influenced by regulators' advice, based on an assessment of the drug stock.

> […] we started as a drug shop in 1997 but later, we changed it into a pharmacy in 2005. […] so, we have been operating as a pharmacy for the last 10 years […]. That happened because of the inspector. You know because, always, when they came and saw the stock volume and other classes of drugs which we had, they said ‘no, this one cannot be a drug shop, it should be a pharmacy'. […] and that is why we had to change to a pharmacy. (P14: LH_Pharmacy_Old FPFP)

5.3. Discussion

This chapter has shown that the formal private for-profit sector in Gulu municipality is heterogeneous in nature and has varying categories which increased across the conflict periods. They provide a range of services to the population in Gulu, including the disadvantaged categories. Very few FPFPs offer specialised services. Most of the services are largely provided on an Outpatient Department (OPD) basis, given that many of the FPFPs did not have the capacity to admit patients to stay overnight.

For many FPFPs, the source of capital for the FPFPs was not large. Capital was mainly drawn from salary savings and resources pooled by a group of friends. From an NIE perspective, this implies that their sunk costs at the start of business was little. Given that the FPFPs are set up to make profits, from a neo-liberal perspective the FPFPs are expected to make profits. However, the FPFP managers had been initially reluctant to respond to this question during the pre-test, hence the question had been removed from the survey questionnaire, but probes were made during the life-history interviews.

The quantitative findings showed that FPFPs gradually increased in number across the conflict periods, with the post-conflict period bringing in more numbers. However, this finding can be best understood in the light of the recollections of the regulators as well as the impressions of health workers in other facilities in Gulu. The

proliferation of the private sector providers in Gulu municipality reflects the neo-liberal assumptions of free entry resulting from reduced government regulation. Although flexibility in regulation was perceived as an opportunity which was exploited by FPFPs to open businesses, it was not perceived as the main factors that led to the proliferation of the sector. Other factors that led to the proliferation of FPFPs included the return of peace; the increase in population and perceived willingness to pay; the demand for specialised services; inconveniences associated with public and PNFP facilities; and systemic health workforce challenges in the public sector. The proliferation of private providers in Uganda in general has already been indicated by other studies conducted in Uganda (Whyte, 1991). The proliferation of the private for-profit entities seems to be a consistent phenomenon nationally. More recently, at national level, the NDA developed the 2019 licensing guidelines for drug shops and pharmacies (National Drug Authority, 2019) with the aim of streamlining the distribution of drugs to private for-profit providers countrywide and ultimately reducing the congestion of such facilities within urban areas, particularly the municipalities, and this seemed to be informed by the increase in the number of these providers. According to the 2019 licensing guidelines, no new drug shops are expected to be licensed in municipalities with existing pharmacies and where drug shops exist; even these should be at least 200 metres from other drug shops and 1.5 metres from other pharmacies. On the other hand, new pharmacies shall be opened at a distance of at least 300 metres from the nearest existing pharmacy in selected municipalities. Gulu municipality is among the municipalities where the new guidelines had to be enforced (National Drug Authority, 2019).

The FPFPs were at varying stages of the organisational life cycle, although many did not experience the stages in a linear manner. Sometimes there was stagnation at one stage and sometimes regression from a progressive stage to an earlier stage. However, the FPFPs experienced some growth dimensions along the way, particularly in areas of human resources for health, equipment and package of services, among others. These areas indicated investments, which from an NIE lens are termed as sunk costs. The FPFPs that had stayed longer in business (older FPFPs) had experienced more development compared to those that had opened less than 10 years earlier (young FPFPs). Furthermore, from an NIE perspective, these investments over time can be interpreted as credible commitment by the older FPFPs to serve their people. Some FPFPs contemplated closing in the face of conflict but stayed the action and were still conducting business by interview time. This also illustrated credible commitment, which created opportunities for them to be targeted as partners for the expansion of coverage for immunisation services (Chapter 8). These partnerships are later illustrated in the networks under Chapter 7.

CHAPTER 6: CHALLENGES, RESPONSES, STRATEGIES OF AND OPPORTUNITIES FOR FPFPs DURING AND AFTER CONFLICT

6.0. Introduction

This chapter addresses research questions 2a) and b). Drawing upon qualitative sources (life histories and key informant interviews), this chapter presents the challenges faced by FPFPs and their strategies during and after conflict as well as the opportunities available to them. The analysis draws on the concepts of evolution and resilience, and on the NIE related concepts of sunk costs, credible commitment, transactional costs, and uncertainty. The challenges and coping strategies of FPFPs during the post-conflict period are presented concurrently. The chapter points out that the FPFPs experienced many challenges against which they innovated coping strategies. The chapter also illustrates that amidst the post-conflict challenges, various opportunities appeared and the FPFPs had to take advantage of them to enter the market or survive the market challenges.

6.1. Challenges and FPFPs Strategies during the Conflict

6.1.1 Insecurity

During the conflict, insecurity emerged as the main challenge for FPFPs, particularly the old FPFPs. Insecurity was a result of two conflicts: a) the fighting between government and Kony rebels; and b) the tribal conflict between the Acholi and the Lango.

At least two of the 'old' FPFPs reported that at two points in time, the security situation was unbearable and extremely risky for human life as well as for business operations.

First, in early 1986, when the war/conflict erupted in the North, it coincided with the takeover by the current ruling government in Uganda. This made the situation in the rural areas of Gulu district unbearable. The situation on the outskirts of Gulu town had become unbearable, hence the owners of some of the businesses that had been located on the outskirts of Gulu town decided to briefly relocate the businesses to the centre of town. This was to enable them to benefit from the security provided by the army, which guarded the town by then. Later in the same year (1986), when the security situation in the town deteriorated, the business owners decided to close shop and leave the town.

> When the war started, we moved the business to town. […] security men were guarding Gulu town. However, from December 1986-June 1987, we were not in town because of the insurgency. We moved out […] who could work here? (P17: LH _ Clinic_Old FPFP)

Second, the tribal conflicts between the Acholi and the Lango tribes (also locally known as Langi) from the neighbouring Lango sub-region in Northern Uganda, which occurred at the start of the conflict in 1986, also exacerbated the security situation, making conditions unbearable for business owners who were from the Lango sub-region. For fear of risking their capital, stock as well as their lives, such business owners decided to close their businesses temporarily and relocate with their stock to safer places, most commonly, their home areas. Some of the managers, who also served as health workers in the public sector at the same time, absconded from duty. However, businesses in Gulu later re-opened when the conditions were deemed to be a little favourable.

Around 1998, the conflict reached its peak again, the security situation in Gulu town worsened, and some of the business owners decided to close their businesses temporarily, as was the case with one of the old clinics. However, businesses in Gulu re-opened later when the conditions were considered a little favourable.

> In 1986, when Museveni [the current president of Uganda] was coming to power and the war here [in Gulu] erupted. There was [also] the tribal thing between the Acholi and the Langi, so we [the Langi] were at risk. I moved back home in Ngai with all the medical stock and kept it in the house. However, I remained working in Gulu hospital briefly and later absconded in 1987. (P18: LH_ Medical Centre_Old FPFP)

6.1.2 Risk of abduction

The risk of abduction was also another effect of the conflict. One of the managers of the FPFPs reported having survived abduction by rebels, who wanted to abduct him so that his services could be used in the bush. He survived by disguising himself as one of his patients and leaving behind all the instruments that could have made easily identifiable as a health worker. However, given the near miss, he greatly attributed his survival to protection from God.

> In 1986[…] they wanted to take me captive […] so they wanted to take me for work in the bush or whatever else they had planned. I survived; it was God's mercy because they got me in the clinic when the patients had lined up. I was seated by the table. […] They surrounded the whole building […] I left the stethoscope on the table […] and posed like a patient […] I passed in between them […]. (P17: LH _Medical centre_Old FPFP)

6.1.3 Reduction in number of clients (and disconnection of Gulu from other places)

Insecurity in the area made access to and from Gulu town difficult, especially for business owners who had started transporting goods to their customers outside Gulu. Many FPFPs highlighted this as a key influencing factor in the marked decline in the number of their clients. In the case of one 'old' FPFP, a wholesale and retail

pharmacy, which also relied on customers from outside town, insecurity made the movement of clients from village to town to buy the drugs difficult and, conversely, the pharmacy owners were unable to take the drugs nearer to the clients. Concerning such challenges, no innovations were reported by the pharmacy owners. All the owners did was to merely hang on.

> […] movement of people from villages to town to come and buy the medicine was not easy. […] we had fewer customers and we were not even able to go to villages to supply those who were there. (P14: LH_Pharmacy_ Old FPFP)

The participants noted that because of insecurity, transport from Kampala city to Gulu town became difficult and Gulu was thus 'disconnected' from Kampala. As a result, one of the managers of a certain old FPFP clinic who had gone for studies in Kampala decided to stay put in the city and only returned when the connecting highway was deemed safe.

6.1.4 Raids

One of the FPFPs reported having experienced raids by the rebels, although by that time, his business was located at the boundary of Gulu town. The rebels looted drugs as well as some hard cash/ proceeds from the business.

> They took my bicycle, I also had made some money, 500,000 shillings [to put dollar equivalent at that time] that day and they took it. They also took some drugs. ([…]. (P17: LH_ Clinic_Old FPFP)

6.2. Challenges and Provider Business Strategies during the Post-Conflict Period

Introduction

The market in the post-conflict period posed numerous challenges to FPFPs. Accordingly, the FPFPs had to implement various business strategies and responses so as to survive. In this section, the challenges and provider responses are presented concurrently. The challenges were categorised into the following themes: increased competition; high operation costs; difficulty in attracting and retaining highly skilled health staff; frustrations with referrals; high expectations from clients; and regulation requirements. The write-up in this section will focus on these. Other challenges included inadequate capital, limited space of operation, seasonal fluctuation of client numbers and sole dependence on the owner.

6.2.1 Increased competition

Increased competition, reflected in increased struggle to maintain old clients or attract new ones, was a major challenge for FPFPs post-conflict. The increased number of FPFPs, described earlier in Chapter 5, was one of the explanatory factors highlighted. The increase in the number of FPFPs led to a spiral of effects, including the concentration, and crowding of FPFPs in Gulu town. According to a manager of a young organisation set up post-conflict, the increasing number of clinics and other FPFPs (already discussed in Chapter 5) was perceived to have caused a reduction in the number of clients, given the stiff competition.

> The number of patients reduced because very many people around here have opened clinics and drug shops are around here, that one also has reduced the patients. (P21: LH_Clinic_ Young FPFP)

> And then, as far as the economic welfare situation is concerned, it has somehow improved. But I think they [FPFPs] are still too many especially around town. (P6: KI_Manager_ PNFP Facility)

One of the participants, who was also working in a public facility at the time of the interview, also confirmed fears of stiff competition. He expressed optimism about the process of rehabilitation and the functionalization of public health facilities in the area during the recovery period. For instance, the functionalization of the pharmacy department in the public hospital would create even more competition for the FPFPs, given that fewer clients would be going to FPFPs to buy drugs. A manager at the private not-for-profit facility seconded his view.

> And when the hospital becomes efficient it is also disadvantageous for private for-profit when the public institutions improve like when we have medicines those fellas will almost close. (P2: KI_ Manager Public Health Facility)

> […] In town [Gulu] the government hospital has been improved but in the past probably ten to five years ago when these clinics were still getting their roots in the government hospital was non-existent if you went to the hospital, they [would] prescribe for you and then you had to go and buy[drugs] from elsewhere. So maybe now that the government hospital has improved. So, they[customers] are also getting challenges. […] why go to two places instead of one? (P6: KI_Manager_ PNFP Facility)

6.2.1.1. Provider responses to increased competition

The FPFP managers devised several strategies in response to the increased competition and these were mainly intended to attract and maintain clients. The strategies are summarised in Box 1 and are described further below.

Box 1

- Marketing of new and old services in both English and Acholi
- Attempts to make attractive reception areas
- Expansion of service package
- Sabotage/provider-induced referrals
- Having a one-stop centre (all services under one roof)
- Flexibility of payment terms: loans and deferred payments, reduction in fees and unbundling of services.
- Use of media campaigns

Marketing of services

To market their services, FPFPs used various strategies, including brochures, noticeboards, and signposts, or behaved in a way that gave the impression that they had a comparative advantage over others. For example, the researcher observed that the majority advertised a long list of services that 'were provided'. Furthermore, the researcher observed that many FPFPs, except the small ones, indicated that they stayed open for 24 hours a day. Some FPFPs used noticeboards in other FPFPs to market their services, as in the case of one imaging centre. For instance, P18, a medical centre, used its noticeboard to advertise new services. However, they were keen to have the advertisement in the Acholi language (see Photo 3).The advert read '*Itwero nongo kony me yat two-jonyo ki kany bene!'* which translates as *'HIV treatment services now available here'*. On probing during the life-history interview, the manager also showed the researcher a private room where HIV testing took place. The manager informed the researcher that, given their consideration and provisions for privacy, they were getting more HIV clients. Photo 3 shows a brochure from one of the medical centres.

Photo 3: An advert for the introduction of ART/ HIV services – Courtesy of Justine Namakula

Having exquisite reception areas

Two of the FPFPs – an insurance company clinic (P15) and a private hospital (P22) – maintained very clean and exquisite reception areas with the intention of creating the impression that the quality of services provided was high and also as marketing gimmick to attract potential clients. However, in some cases, some of these features instead created a perception that these facilities were awfully expensive and were meant for only the ‘rich’.

Expansion of service package

As indicated in Chapter 5, all the five old FPFPs reported that they had introduced new services in the post-conflict period. One interesting finding concerns a private hospital (P22) that had innovated by introducing an ambulance project called ‘Rapid Response Unit' to respond promptly before ‘any other provider’ in case of an accident in town and then take patients to the private hospital for treatment. P22 was the only one with an ambulance among the FPFPs in Gulu municipality. One of the medical centres (P17) introduced HIV services.

Provider-induced referrals

Some of the FPFP managers, who were also working in other non-FPFP facilities, were reported to have ‘sabotaged’ equipment at these facilities and later referred the patients to their private businesses. These allegations were made particularly in connection with those working in X-ray departments, as the manager of a public hospital stated. When these allegations were followed up, the manager of the X-ray centre denied them all and instead blamed the failure of the equipment on a lack of timely servicing and repair.

> The people in the X-ray, some of them even damaged the machines here […] so he can use the others in his business when these get spoilt. (P2: KI_ Manager Public Health Facility)

Given that the same manager had his private clinic in another district neighbouring Gulu, he expressed the concern that the FPFPs could also sabotage one another to push their competitors out of business and retain the customers.

> Then there is intrigue. People fight you. You know it is a business! They want you to close so that they continue. They are fighting for business. (P2: KI_ Manager Public Health Facility)

One-stop centres

In the post-conflict period, the majority of the FPFPs, specifically those that had been in business for some time, decided to provide certain services in-house as a way of cutting costs, creating a one-stop centre and therefore increasing their competitive advantage. For example, private hospitals and some clinics incorporated both laboratory and drug sale services. In this case, the clients could access the services in one place, rather than having to be sent to another FPFP facility to get some of the services, a situation where there was no guarantee that the patient would return. The researcher also observed that many of the clinics, including P21, had a pharmacy embedded, while a few had a laboratory.

Flexibility of payment terms

The FPFPs implemented several strategies aimed at ensuring flexibility around payment with the aim to maintain clients by reducing their financial burden, which was perceived to be brought about by one-off payments. These included price reductions, loan books, deferred payments, and reduction in fees. These were also some of the mechanisms that FPFP managers put in place to enable the poor to access health

services within the FPFP facilities. Details of these as well as perceptions of who a poor person is are presented later in Chapter 8.

Use of media campaigns

One of the managers from an insurance company clinic (P15) used media campaigns to not only market their services but also address the negative image of the clinic as being expensive. The manager noted that because of the campaign, the number of clients and the income had increased. The same manager reported having lobbied religious leaders to encourage potential clients to access services at the clinic and used emails to communicate with clients who had utilised the services before.

> Hmm, I go to pray at Watoto Church. I also talked to the pastor. And they sent all their prayer people to come here for services. (P15: LH_ Insurance company clinic _Young FPFP)

6.2.2 Provider responses to high operating costs (cost-cutting strategies)

The study found that FPFPs experienced high operating costs in running the businesses. These costs included high costs of drugs, high rental fees, ever-escalating electricity costs but irregular power supply, high and ever-increasing operating licence fees, high municipal council taxes and challenges in paying staff. Notably, some of these operational challenges were not collectively experienced by FPFPs; rather, they were mentioned by only a few FPFPs.

The age of the business also seemed to have had an impact on which challenges were reported by some FPFPs. For example, both the young and the old FPFPs reported that they paid rental fees, although more of the young FPFPs reported this. Only two FPFPs did not report payment of rental fees. By the time of fieldwork, some old FPFPs had *'constructed their buildings'.* However, old FPFPs and the managers

of many young FPFPs, which were still renting business space by the time of fieldwork, persistently complained about the ever-increasing rental fees. A health worker from another FPFP clinic that participated in an in-depth interview shared this view:

> One of the challenges that we are facing is that we have extremely high rent charges which increase every year. In 2012, we paid 450,000/=, in 2014 it was around 400,000/=, the last year 2014 it was 550,000/= and this year it is 650,000/= shillings. (P4: KI_ Health Worker_Other FPFP Facility)

Licence fees and taxes paid to the government and the municipality, respectively, were reported by both the young and the old FPFPs. Only the old FPFPs reported a pattern of ever-increasing operating licence fees over time. However, a health worker who also doubled as a manager of a one young FPFP (an NGO clinic) expressed unhappiness about the burden of having to pay taxes for signposts in addition to paying the licence fee.

> The municipal they demand even over 600,000/- […] the municipal demands over 600,000/- as trading licence... […] for the signpost, […] we must pay for signposts separately. […] for the operation licence, people especially the private practitioners are not happy, and they are complaining. (P1: KI_ Manager_ Other FPFP Facility)

FPFPs devised several cost-cutting strategies in response to the high operational costs. These included mobilisation of resources to buy their place or partitioning a room, hiring part time-staff as well as low cadre staff, purchasing cheaper brands of drugs and storing reagents in a water pot. Many of the cost-cutting strategies had implications for quality. Interestingly, none of the FPFP providers highlighted any quality implications. Only regulators highlighted this issue during the interview in relation to the challenges they faced when regulating and supervising the FPFPs themselves.

> Another thing is I know how they are struggling with the supplies, the medicines when the prices keep fluctuating and then also the quality of medicine, they buy is also sometimes a problem. You have been seeing NOVAT-02 here. If the drug is from India the quality is poor. They will give the patient, will not improve; they will come back and later they will say, for me I will not come back to this clinic. (P12: KI_Regulator_ District level)

> The specialists are the part-timers. […] Like someone is working in the [public] hospital but they also come and work here. […] we cannot have them as a full-time staff […] they are expensive. But it is not only that, a good number of the specialists tend to work at different hospitals. (P15: LH _Insurance company Clinic)

> Some of them use nursing assistants who are not much experienced. (P9: KI_Regulator_ District level)

As indicated in Photo 4, found on the noticeboard of one of the NGO clinics which specialised in the provision of reproductive services, clients were charged a fee for the services. This was one of the survival strategies aimed at making up for reduced donor funding.

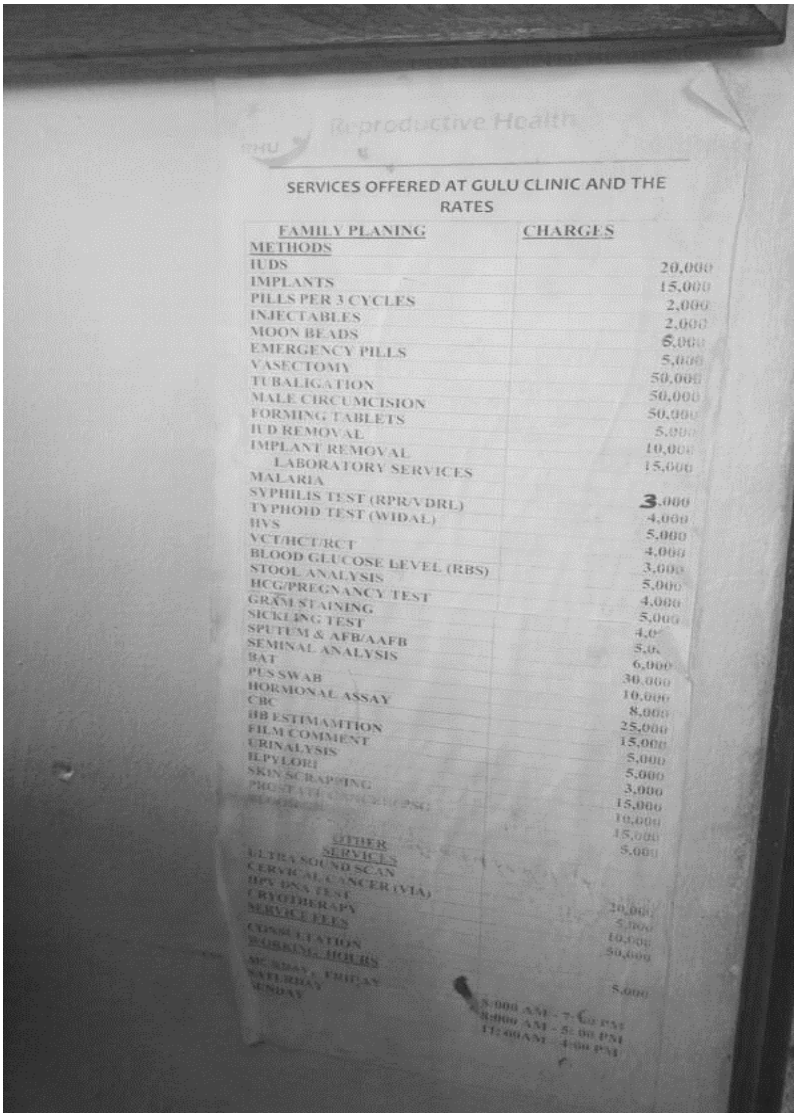


Photo 4: Prices of services in one of the NGO clinics – Courtesy of Justine Namakula

6.2.3. Provider responses to health workforce challenges

The FPFPs faced challenges in attracting highly qualified/skilled staff, and even when they were successful in attracting them, they were unable to retain them for long. This is because specialists are few, very marketable, expensive, and already working elsewhere in other non-FPFP facilities. These skilled staff included specialist cadres of health workers such as gynaecologists, orthopedic surgeons, physiologists, and medical doctors. High turnover of specialists was reported to have happened in the

period immediately after the end of the conflict, through 2007, 2009 and 2012, and continued to be a challenge by 2015 (fieldwork time).

Turnover of specialists was due to the attractive labour market for health workers in neighbouring South Sudan around 2011, and the health workers migrated there in search of better renumeration (Namakula et al., 2011). In some cases, the staffing gap was unintentionally created by the official transfers, which are provided for in the Uganda Public Service Standing Orders (Government of Uganda., 2010). This is a legal document which deals with the management of staff in public service and issues concerning terms and conditions of service. It states that staff in public service are supposed to be transferred after at least three to five years of working in each station and that non-compliance with this formal procedure results in disciplinary action (p.99). Despite the dire staffing needs and challenges related to recruitment and attraction (refer to document review) created by the conflict in Northern Uganda, the policies on official transfers did not change (Mangwi et al., 2019).

Two of the FPFPs that shared a gynaecologist who was working in the public hospital reported that they lost out because he was transferred to other regions under the deployment policy for health workers. One of the clinics reported a turnover of two dentists, within a given period, one of whom left to set up his own clinic. In most cases, the turnover of such specialist cadres affected the FPFPs as they found it difficult to replace the specialists. This meant, too, that such FPFPs also lost the competitive advantage of offering such specialist services. As highlighted by a clinic and a private hospital, the coping strategies included the continuous replacement of lost specialist cadres as well as abandoning the provision of such services altogether.

> Initially, we had two gynaecologists. One was a medical doctor and but also specialised in gynaecology and the second one, Henry [not real name], was gynecologist – specialist. The medical doctor worked until 2009 and so we brought in Dr. Peter [not real name] because we needed one who was both a medical doctor and a gynaecologist. However, Dr. Henry [not real name] worked here from 2009-2011 and he went to South Sudan. Dr. Peter also left in 2012 and went to Mbale Regional Referral Hospital[…]we don't have a gynaecologist right now[…] it has really affected us, we don't have a gynaecologist and so many people come wanting to see one but we don't have. (P18: LH_Medical centre_ Old FPFP)

> Dr. Oketch [not real name] the gynaecologist left in 2006 when he was transferred from here to Mbale Regional Referral Hospital. Then the orthopedics also left in 2007 […] even the physio left and was replaced by a certain lady and she is gone now. (P22: LH_ Private Hospital_ Old FPFP)

The regulators at the national and district levels who were interviewed as part of this research also confirmed that FPFPs faced challenges related to attracting, recruiting and retaining skilled health staff. One of the regulators at the national level attributed the retention challenges to the high operation costs. For example, rental fees made it difficult for FPFPs, particularly the smaller ones, to pay and retain skilled staff. As a result, the skilled health workers spread their working hours across various FPFPs to get an aggregate benefit which, in the end, was perceived to affect actual quality. Another regulator pointed out that some FPFPs resorted to hiring lower cadres as a coping strategy.

> […] these midwives of ours [that subscribe to the organisation] in these clinics are nurses [by cadre], they cannot afford to pay a nurse at the diploma level. […]it is costly and yet some of them are renting, so […] because they are unable to pay salaries, definitely the staff will run away, or if the staff stays, they will moonlight in one clinic then another clinic in the evening and another clinic in the night.[…] so the quality of service is not kept up. (P13: KI_Regulator_ National level)

> […]so, they tend to hire lower cadres- These who can accept low pay. […] Otherwise, you have to pay out all your profits and then you will remain with nothing. (P12: KI_Regulator_ District level)

6.2.4 Provider responses to high expectations from clients

One FPFP manager and two regulators highlighted the challenge of high expectations from the clients. This arose from clients' desire to have 'value' for the money they paid. The expectations included the flexibility of opening hours, the availability of all services required by a client and the ability prescribe and provide some medicine regardless of whether it was necessary or not. In some cases, the inability of FPFPs to satisfy their clients' expectations and demands harmed the relationship between the two parties involved in the transaction. Coping strategies included implementing flexible opening times and offering thorough explanations as to why the facility is unable to provide certain services even when the client has an effective demand for them. Some FPFPs instead referred such clients to non-profit facilities which could offer such services.

> […] I think people's expectations are so high […] for example, expect you to be in the hospital all the time. So, we decided to open for 24 hours a day. […] Some women may come to deliver here. We explained 'this is a clinic, so we do not do deliveries. […] another expectation is that of X-rays: someone breaks their leg and runs here. […] We refer them to Gulu regional referral hospital because it is the nearest. (P15: LH _Insurance Clinic_ Young FPFP)

> […] their clientele has high expectations which they cannot meet; people think that if I pay for service, I expect ABCD. Normally people who go to PFPs have a certain level of knowledge so their expectations are high and they demand a lot, so they have increased levels of litigation, every other day they [FPFPs] spend money in court in and out. (P13: KI_Regulator_ National Level)

> It is difficult sometimes to satisfy patients […] a patient will pay money but expect many services to be offered. […]. For example, the patients may come with some problems the results are negative. They [FPFPs] will not give any medicine yet the patient has paid. […] and the patient feels like 'I cannot go back home without medicine'. (P12: KI_Regulator_ District level)

6.2.5 Provider responses to strict regulatory requirements post-conflict

The general impression among the key informants was that the regulation of FPFPs became stricter in the post-conflict period regarding who could open a health business. This resulted in business-minded health workers opening up FPFPs. However, information found in the guiding documents for the operation of some of the FPFP categories revealed relative flexibility within the tight regulatory measures, particularly in relation to opening of FPFPs, where provisions were made for non-professionals to register and work under the supervision of professionals. For instance, the Uganda National Drug Policy Authority Act, Cap. 206(National Drug Authority., 1993), which is intended to provide a framework for the regulation of dug shops and pharmacies, provides for flexibility by making provisions for licensed persons and licensed sellers. It states:

> […] A licence will be granted if the authority is satisfied that that the business, so far as concerns the restricted drugs, will be carried on under the immediate supervision of a pharmacist in each set of premises where the business is to be carried on (Section 14b). A person who carries on the business of a pharmacist without a licence issued under this section commits an offence and is liable to a fine not exceeding one million shillings or to imprisonment not exceeding five years or both (Section 14 (3), P.14.
>
> […] If, on application made in the prescribed form by a person other than a pharmacist or a licensed person, the authority is satisfied—(a) that the applicant is fit to carry on a business of supplying by retail restricted drugs, other than drugs of class A or B;(b) that the area in which the applicant proposes to carry on that business is not sufficiently served by existing facilities for the retail supply of the drugs; and (c) that the applicant is an authorised person, the authority may issue to the applicant a licence authorising him or her, subject to any conditions specified in the licence (Section 15(1).p.15).

Many of the FPFP managers reported that business-minded people did not have the authorized qualifications to open a pharmacy or drug shop. However, they instead decided to innovate around Section 14 of the National Drug Policy Authority

Act by signing a paid contract with a qualified cadre to work as a quasi-owner/supervisor of the business. In this case, if any queries arose, the contracted person would be answerable. This innovation seemed more common and, therefore, became the new norm within this setting.

However, the study found that some FPFPs experienced challenges with these transactional contracts with 'supervisors. Two of the managers complained about the unpredictable increase in the fees charged by those contracted as well as the threats to cancel the contracts in case the fees were not increased to the desired amount. In response, some of the FPFP managers resorted to negotiating a 'favourable' fee or identifying another 'supervisor'. In the case of P16, which was found to be transitioning from a drug shop to a clinic, the manager was wary about the extra costs that the identification of another cadre would involve.

> Well, he [the supervisor] tried to complain that the money was little, but we also told him that money nowadays is little because there are very many pharmacies. (P14: LH_Pharmacy_ Old FPFP)
>
> […] and now I must change the supervisor from pharmacist because I am turning my business into a clinic. (P16: LH_ Drug shop _ Young FPFP)

In relation to P16, the researcher observed that the signpost was hidden away from the road, where it would normally be expected to be positioned to enhance the visibility of the business. On probing, the manager reported that since the partitioning was still underway and registration of the upcoming clinic was not yet finalized, he was safer hiding the signpost.

Another issue reported with respect to enforcement in the post-conflict period was the suitability of premises and the storage of reagents. The National Drug Policy and Authority Regulation 2014, No. 36 stipulates conditions that need to be available in a

business before a certificate of suitability of premises is awarded, without which one cannot operate a business. These include cleanliness of the premises, regular water supply, enough space, good lighting and appropriate storage of drugs and materials (National Drug Authority., 2014). The researcher observed that all facilities she visited had clean premises. However, in relation to space, she noted that many used plywood to partition so that they could appear to have more space. Two of the clinics had resorted to having a laboratory in-house and they ensured that within the partition, the microscope was placed next to the window, which would bring in more natural light.

The National Drug Policy and Authority Regulations for the suitability of premises also states that some materials need to be protected from light and that the ingredients and finished drugs that are temperature-sensitive shall be kept in a temperature-controlled storage facility (Article 15(2), p.7). The regulators seemed to be aware of this and tried to check the compliance of facilities during their inspection visits. However, compliance with this regulation seemed limited, particularly for the some of the young FPFPs that had to grapple with unstable power supply and to keep up with the high costs related to electricity bills. The situation was reported to be worse for the smaller businesses whose income could not enable them to purchase and maintain a generator for power back-up. In response, they implemented innovations which, in turn, raised serious issues of quality of healthcare. One of the regulators highlighted the shortcuts he discovered with respect to the storage of reagents during some of his inspection visits and was concerned about the side effects.

> Some of the reagents require storage in a refrigerator and many of them do not have refrigerators. I have seen few of them putting the reagents in a kaveera [polythene bag] and they dip in a water pot […] that is why we get purported disease outbreaks. (P10: KI_Regulator_ District level)

Interestingly, whereas the regulatory bodies at national level such as Uganda Medical and Dental Practitioners Council (UMDPC) Act (Uganda Medical and Dental Practioners Council., 1998) Article 32(2)) and the Allied Health Professionals Act (Allied Health Professionals Council., 2000)Article 35(2)) call for inspecting officers to make a report about the inspection to the councils, none of the regulators at district level mentioned this. When probed further, some mentioned having given warnings and advice to the facilities to improve.

6.3 Opportunities for FPFPs Post-Conflict

This section is a description of the opportunities for the FPFPs in the post-conflict period. Opportunities are different from coping strategies because they may present a favourable time or set of circumstances in which FPFPs can take advantage. Coping strategies, on the other hand, are responses to problems that can impede the performance of the FPFPs.

The study identified several opportunities for the FPFPs in the post-conflict period. All the factors mentioned under section 5.22 opened opportunities for the FPFPs either to get established or to navigate the market and ultimately support their business strategies. Other additional factors that presented opportunities included new partnerships and opportunities for resource mobilisation. To avoid repetition, this sub-section only explains the additional opportunities. These are explained in detail below.

New partnerships

New partnerships with the district as well as partnerships with NGOs and other organisations, such as banks and supermarkets, were reported to have started around 2012/2014 and were still happening around the time of fieldwork in 2015. Although such partnerships were mainly reported by well-established businesses/ 'old' FPFPs, a few young FPFPs with high marketing skills (e.g. an insurance company clinic, the private hospital and one clinic) also reported such experiences. The partnerships provided FPFPs with opportunities to contribute to wider health system coverage goals, to market the services available to potential clients, to train in self-regulation, to become health management organisations – as in the case of the facility-based insurance company clinic – and also to procure drugs and equipment at subsidized prices or on deferred payment. In Chapter 7, the researcher revisits the benefits of the partnerships and relationships between FPFPs and other providers in detail.

Resource mobilisation with existing international NGOs/donor programmes

Although scarce, there were opportunities for FPFPs to conduct resource mobilisation. For example, a manager at one of the FPFPs reported that, together with the existing NGOs in the area, they were planning to write proposals and request funding.

6.4 Discussion

This chapter has shown that the market in which FPFPs operated presented challenges for them to navigate during and after the conflict. The FPFPs faced numerous challenges, some of which directly resulted from active conflict and yet

others were related to operational costs and the changing regulatory context. Avis (2016) notes that the market in conflict-affected settings is not without challenges. However, this chapter has highlighted the agency of sector actors to seek solutions to challenges. For example, FPFPs innovated business strategies in response to the numerous challenges in the post-conflict period, including those that would sabotage others, hence reflecting the social Darwinist principle of '*survival of the fittest*' (Gregory, 2000) This principle is also reflected in the neo-liberal assumptions of competition and privatization, as well as resilience of the private sector in post-conflict settings.

Sweeney (2009) argues that the private sector providers are resilient to systemic shocks and contextual challenges, as they can often change shape and direction and survive difficult situations. This closely reflects Vogus and Sutcliffe's (2007 in Gilson et al., 2017) definition of resilience as 'the maintenance of positive adjustment under challenging conditions such that the organisation emerges from those conditions strengthened and more resourceful'. For example, the chapter has illustrated growth dimensions of the old FPFPs during the conflict and continued growth in the post-conflict period, when faced with stiff competition. This concurs with the 'everyday resilience' concept (Gilson et al., 2017), albeit it was mainly applied to the public health system. Everyday resilience refers to 'the ability of health systems to continue to deliver services in the face of constant challenge and strain. Everyday resilience derives from the combination of absorptive, adaptive and transformative strategies that actors in systems adopt in responding to strain' (Gilson et al., 2017).

At the individual level, everyday resilience was reflected through the experience of some managers of FPFPs, particularly those that experienced near-miss abductions or had had their businesses raided, among other challenges, during the conflict. They coped by disguising themselves as patients, hiding their stethoscopes, in some cases closing their businesses and moving to safer environments, only to later return and re-open the businesses when they perceived that the situation had improved. Such coping strategies are not only indicative of the resilience of other health workers who worked during the conflict in Northern Uganda (Namakula and Witter, 2014) but also of the resilience of private sector businesses operating in fragile and conflict-affected areas, as reflected in the work of the World Bank (World Bank, 2005). Gilson et al. (2017) refer to interconnected 'individual and organisational capacities' in which 'an organisation's capacity for resilience is embedded in a set of individual level knowledge, skills, and abilities and organisational routines and processes by which a firm conceptually orients itself, acts decisively to move forward, and establishes a setting of diversity and adjustable integration' (Lengnick-Hall et al. 2011 in Gilson et al. 2017).

However, the chapter has shown that some coping strategies adopted by FPFPs, specifically those related to coping with the regulation of storage of reagents as well as with personnel challenges, had implications for the quality of services provided by the FPFPs. This emphasizes the need for regulation of the sector. Indeed, Asiimwe (2018) and Ssali (2018) express concerns about such negative effects of market-led health systems and underscore the need for the 'return of the state' in health service provision in Uganda. The implication of this finding, therefore, is that the private sector

needs to be regulated, and regulated effectively. Regulation here reflects the formal norms/institutions governing the operation and behaviour of the FPFPs.

The chapter has also shown that there are several opportunities for FPFPs in Gulu after the conflict, hence the post-conflict period provided a window of opportunity within the broader context for FPFPs. For instance, some FPFPs were able to get established but also get clients. The reduced role of regulation, as well as its perceived flexibility during the post-conflict period – which in part mirrors a weakness of the legal institutions – has specifically been highlighted as one of the opportunities that enabled FPFPs not only to increase in number but also to cope with the regulatory requirements. This again reflects the effects of the deregulation (proposition 9) of neo-liberal reforms (Williamson, 2004). However, the challenge of increased competition, which was reported as a spin-off effect of the increased number of FPFPs in the post-conflict period, also illustrates the effects of deregulation. Furthermore, the chapter indicated that opportunities for resource mobilisation for FPFPs were minimal, and this is also one of the challenges noted by Avis (2016)

CHAPTER 7: RELATIONAL NETWORKS FOR FPFPS AND OTHER ORGANISATIONS

7.0. Introduction

Relationships between FPFPs and others are envisaged as part of the dynamics of the healthcare market. Hence, this chapter seeks to address part c) of the second objective, which focused on understanding the relationships between FPFPs and other organisations within the market. This chapter draws largely on the life-history interviews and, to a small extent, the organisational survey data. The analysis in this chapter combined thematic analysis and social network analysis (see section 4.6.3). Hence, throughout this chapter, network maps which were developed using social network analysis will be used to illustrate relational links. The analysis of the data for this objective was mainly based on the NIE concepts of networks as a form of markets and contracts. Earlier, in Chapter 6, it was noted that the FPFPs were faced with numerous challenges and high operational costs. Consequently, networks and linkages with others provide a form of coping.

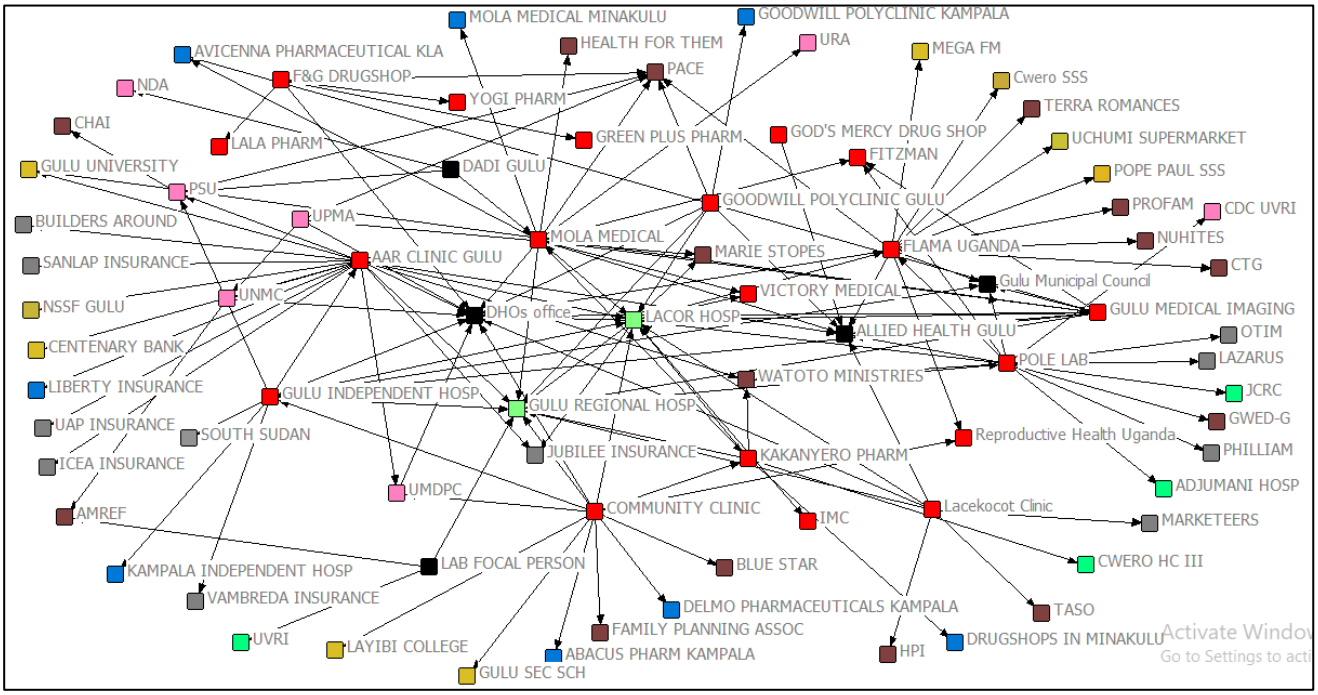
First, this chapter presents the general relationships between FPFPs and other organisations and then elaborates, in greater detail, on selected key relational links within the network. For the most important organisations within each of these networks, the challenges as well as the benefits are noted in some instances. This chapter is limited in that it does not indicate the changes in the network over time. This is because the networks and linkages that the FPFPs were asked about were only those for two years leading to the time of data collection. The main argument in this chapter is that there is interdependence and a connection between FPFPs and

other organisations; this also emphasizes the blurry nature of the boundaries between FPFPs and other organisations, including the public facilities.

7.1 General Relationship between FPFPs and Other Organisations

The study sought to understand the relationships between private for-profit providers (FPFPs) and other providers in Gulu municipality. Figure 28 illustrates the dense/thick network of FPFPs in Gulu. The FPFPs in Gulu (coloured red) had linkages between themselves and with FPFPs outside Gulu town (coloured blue), non-FPFP facilities in Gulu and beyond (coloured green), NGOs/CSOs within and beyond Gulu (maroon), regulators at national level, including professional bodies (pink) and regulators at district level (black). FPFPs also had linkages with non-medical organisations (yellow). Other organisations with whom FPFPs had relationships included non-facility-based insurance clinics and non-health organisations. In the figure, there are indications, too, that other organisations within the network also have relationships among themselves. However, the discussion in this chapter will mainly focus on the linkages where the direction of the arrow flows from the red box to a box with any of the other colours mentioned above (only links between FPFPs and others)

Figure 28: General network for FPFPs in Gulu



Key to network map for general relations

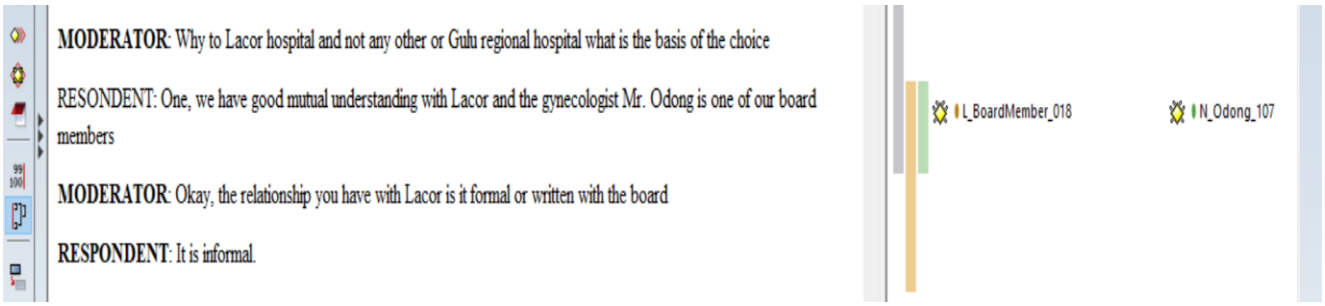
	FPFPs in Gulu
	FPFPs outside Gulu
	NGOs and CSOs in Gulu and beyond
	Non-health organisations
	Regulators at national level (including professional bodies)
	Regulators at district level (including professional bodies)
	Others (non-facility-based insurance companies, Individuals

7.1.1. Types/forms of relationship

The relationships between FPFPs and other organisations were either formal or informal. According to the participants, formal relationships were those perceived as based on an agreement whereas informal relationships were those that emerged because of interactions or relationships between individuals working in relating organisations. In some cases, the informal relationships were later formalized, while in other cases, they remained merely interactions between individuals. Figure 29

shows an extract of coded data indicating an informal relationship between one of the FPFPs and a gynaecologist working in the mission (not-for-profit hospital).

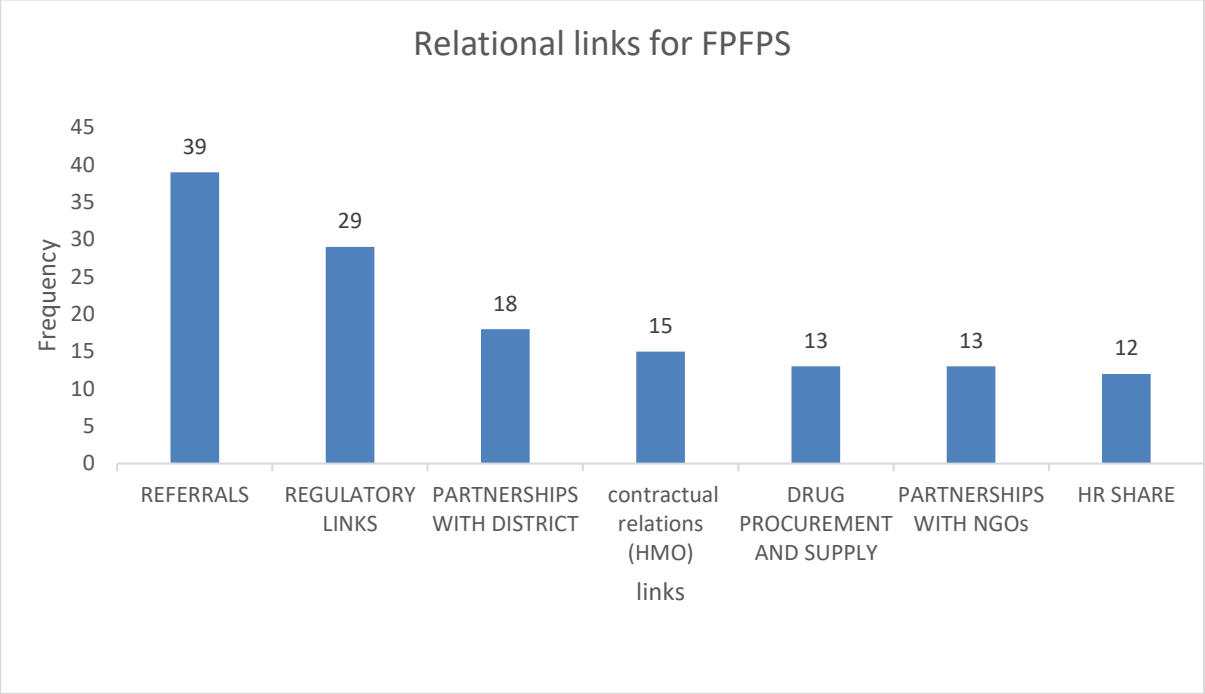
Figure 29: Data extract coded for content for organisations linked through individuals (ATLAS.ti)



7.2 Relational Links

The relationships between the FPFPs other organisations, which are represented by arrowheads moving towards or away from the red boxes in Figure 28 were mainly driven by the exchange of resources or assistance rendered by one organisation to another and are, from this point forward, referred to as relational links. As noted earlier, through coding with ATLAS.ti software, 35 relational links emerged; these were later merged into themes and this is illustrated by Figure 30.

Figure 30: Relational links of FPFPs by frequency of mention



Source: Organisational life histories

Although the study found numerous relational links, this analysis focused on seven that scored an average of 4 (mentions) and above, as indicated in Figure 30: referrals; regulatory links; partnerships with districts; partnerships with NGOs; contractual relations (health maintenance organisations [HMOs]); drug procurement and supply; and HR share. The remaining relational links are clustered into 'others', including branches outside Gulu, board member, marketing drugs, hybrid, ambulatory service, waste management and funding but details about these were excluded from analysis.

7.2.1. Referral relationships

Referral relationships emerged as having the densest network (one that was mentioned most within the interviews). Figure 31 shows the most central

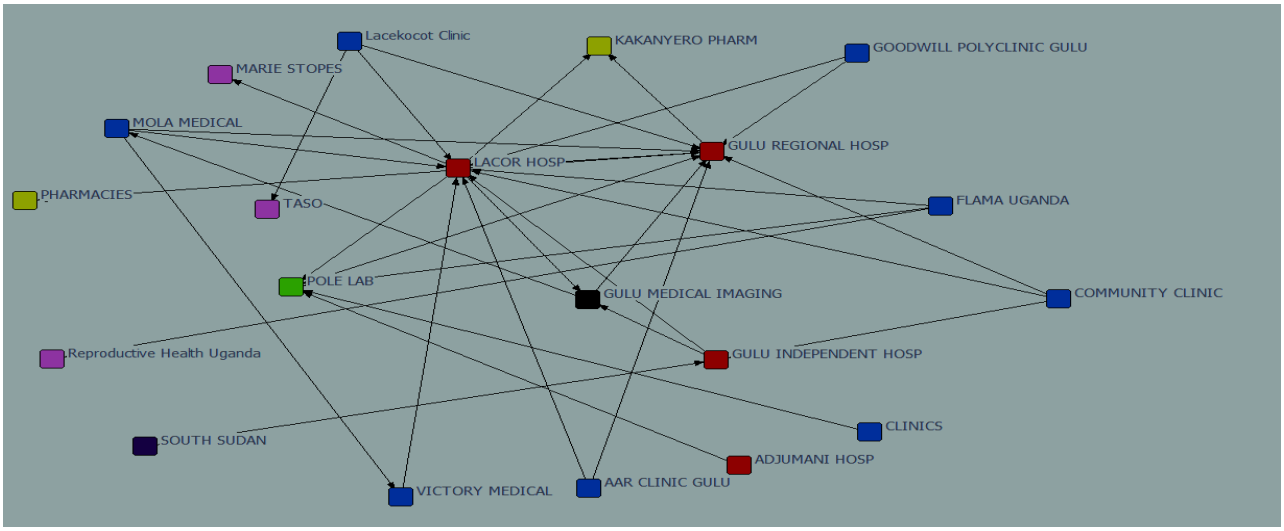
organisations[36] in the referral network, with the private hospital as one of three facilities that play a central role within the referral network. The other two comprise the state's regional hospital (Gulu Regional Referral Hospital) and the non-profit mission hospital (Lacor Hospital). This is illustrated by the many lines that are connected to them.

These hospitals played a unique role of handling obstetric care and emergencies, major surgeries, chronic illnesses, and specialised services, among others. For example, AAR Clinic Gulu has a referral link to both Gulu Regional Referral Hospital and Lacor Hospital (both state and non-profit), hence the lines pointing towards these two hospitals. The community clinic also makes referrals to the private hospital as well as the government hospital.

Figure 31 further shows that within the network, there was also a stand-alone clinical laboratory and an X-ray imaging centre, which carried out unique diagnostic tests and offered X-ray and imaging services, respectively. For example, one Clinical Laboratory reported that they received referrals from the public hospital, the mission hospital, clinics in Gulu and hospitals located in the Lango sub-region. One pharmacy located at in the yellow box at the top centre of figure 31 played a role in drug procurement, given that it reported having received referrals for drugs from both the public and the mission hospitals. Figure 31 also shows that referrals for HIV services seemed quite rare. For example, only one FPFP facility, reported having referred patients to an NGO which offers HIV/ AIDS care and support in the area for further care.

[36] One that had more lines in relation to referrals

Figure 31: Referral network for FPFPs in Gulu



Key

	Hospitals
	Stand-alone laboratory
	X-ray and imaging centre
	Clinics, medical centres, HC II
	NGOs with clinics
	Pharmacies

7.2.1.1 Challenges associated with referrals between FPFPs and other providers

Mistrust and frustration were associated with the referral relations between FPFPs and other non-FPFPs. According to managers of two FPFs who were interviewed, this mistrust was perceived to be expressed in part through the poor attitude of staff towards patients that had been referred and total disregard for the referral notes at the receiving end. This poor attitude was attributed to the benefits and profits FPFPs were perceived to enjoy compared to those who worked in non-FPFPs. This mistrust was ultimately reported to have resulted in negative consequences for patients, such as delays in receiving medical attention and death.

> But there are some [facilities- PNFP and public] that still do not accept our referrals. They do not consider us or our files. They would start all afresh. […] For us we continue to refer but now the patient is the one that suffers. They will say we do not listen to [name of medical centre]. (P18: LH Medical centre _ Old FPFP)

> Somebody […] may envy you because you are driving and say, 'she is richer than me who works here with government'. […] such attitude is the one making clients suffer. (P1: KI_ Manager_Other FPFP Facility)

One of the managers of the public hospital perceived the referrals, particularly in relation to X-ray equipment, to be induced by health workers who were doing dual practice in the public hospital and in their private business. He suspected failures in the X-ray machine to have been an act of sabotage by a staff member who also worked in the FPFP aimed at having patients go to their business outfit, which exclusively provided X-ray services.

> Some of the people working in the X-ray department damage the machines here at the hospital. […]. When they [machines] are spoilt, they send clients to their business. […]. (P2: KI_Manager public facility)

Some of the FPFPs innovated around the challenge of referral-related hostility and enabled improvements in the way referrals were handled at non-FPFP facilities in the area by first creating formal agreements with individuals working in the non-FPFP facilities. As indicated in the quote below, a formal relationship between an FPFP HCII and a health worker in a PNFP facility (mission hospital) resulted in a formal arrangement for referrals and ultimately positive results for the patient.

> We usually refer to Lacor Hospital and not Gulu […] we have good mutual understanding with Lacor and the gynaecologist Mr. Opalat [not real name] is one of our board members. […] (P1: KI_ Manager_ Other FPFP clinic)

Previously, deliberate efforts were made by the district to enhance discussions between FPFPs and other health providers in the public and the PNFP sectors in the municipality with the aim of improving referral collaborations. However, discussions were perceived as inadequate in relation to solving the challenges, given that they

resulted in the dissemination of mere directives for FPFPs to refer clients to the public and mission hospitals,

> In 2013, we had a workshop organised by Gulu district health team and Ministry of Health. As FPFPs, we complained but we were told that referrals must be made to Government Regional Referral Hospital and the PNFP hospital. (P18: LH Medical centre _ Old FPFP)

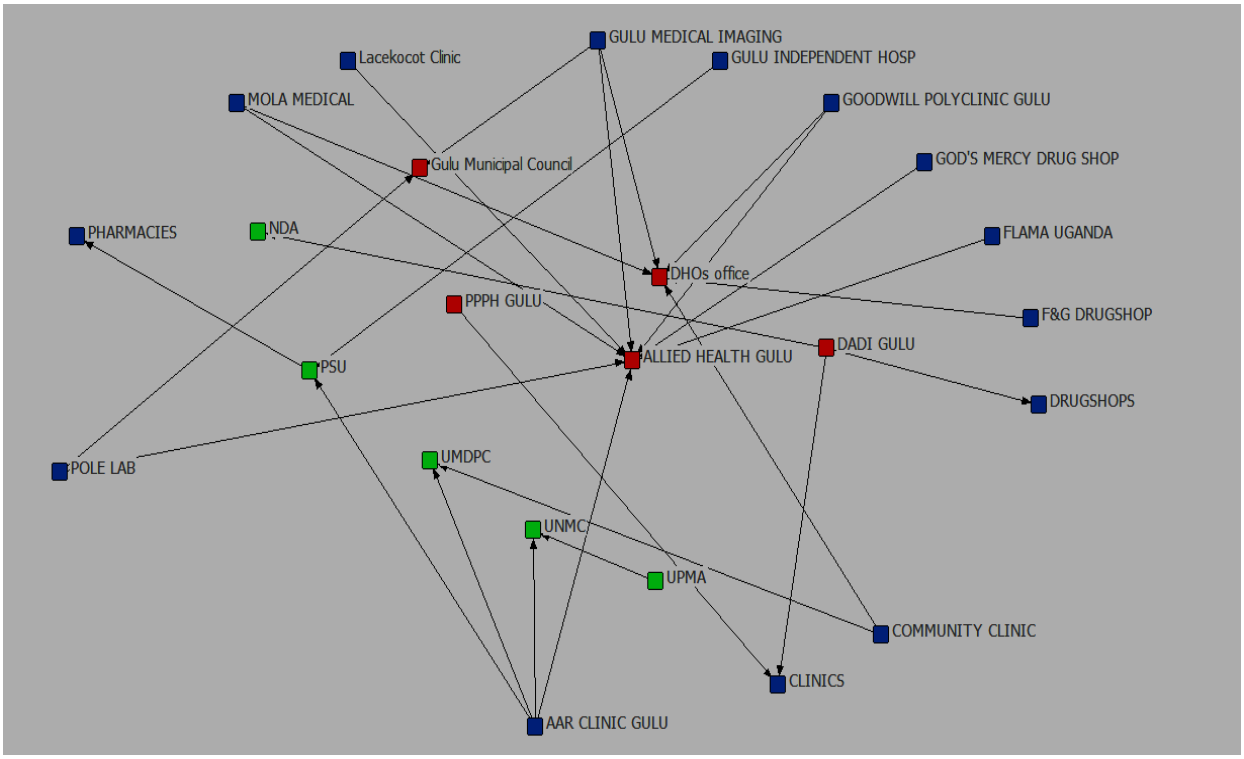
7.2.2 Regulatory links

The network for regulatory links for FPFPs is illustrated in Figure 32. The FPFPs (coded blue) have a relationship with regulators at district (colour-coded red) as well as national level (colour-coded green). At district level, the DHO's office (although interestingly mentioned by few FPFPs), which is one of the regulators at district level, plays a central role in the regulation of FPFPs. It does this mainly through its associate offices located at the district headquarters within the same compound. These include the Public Private Partnership for Health (PPPH) office, the DDI Gulu, Allied Health, and the laboratory focal person. Their responsibilities included the enforcement of registration and payment of annual operating licence fees on behalf of the professional bodies as well as conducting supervision to ensure quality of serviced provided. The Gulu municipal council authority was also mentioned as a regulatory body in charge of collecting business taxes from FPFPs, which contribute to the district local revenue.

Furthermore, regulators at national level (coded green) were mainly professional association bodies such as Uganda Medical and Dental Practitioners Council (UMDPC), the Pharmaceutical Society of Uganda (PSU), Uganda Nurses and Midwives Council (UNMC), Allied Health Professionals, Uganda Private Midwives Association (UPMA). Within the National Quality Improvement Framework in Uganda,

the professional councils are responsible for the regulation of professional standards, ethics and code of conduct. They are also entrusted with the power to recognise and reward good performance and also sanction or institute disciplinary measures for professional misconduct (MOH, 2015). The professional councils have adapted the implementation of their roles through the enforcement of payment of association and subscription fees, supervision, legal cover as well as punishment for offenders. As summarised in Table 20, there are variations in the amount of membership fees paid by cadres based on professional speciality, nationality (non-Ugandan fees are usually higher), fines for defaulting in renewing membership and cases handled in relation to misconduct as enforced by the Uganda Medical and Dental Practitioners' council.

Figure 32: Regulatory links for FPFPs in Gulu



Key

Regulators at district level
Regulators at national level (mainly professional bodies located outside the municipality with offices in Kampala)
FPFPs

The managers of FPFPs expressed an appreciation of the relationship with professional associations although the majority were unaware of the status of their members' subscription to the professional bodies for that year. Three advantages of the relationship with professional associations emerged. These included a sense of belonging, a collective bargaining voice for FPFPs with the claimants as well as being able to have legal cover and favour in case of any issues.

> They [professional bodies] can protect you, but they can also demote you if you do something stupid […] If you are a registered person and you are engaged in doing quack things. (P4: KI_ Health Worker_ Other FPFP)

When probed about the circumstances under which health workers were protected/provided with legal cover, the registrar for one of the professional association bodies clarified that investigations need to be undertaken first. Should the health worker be found guilty of the accusations against them, then a punishment would be enforced accordingly. According to the Allied Health Professionals Act, Article 27, punishments for professional misconduct and moral turpitude range from paying a fine to the revocation of licences, whereby the latter is operationalised by removal of the cadre's name from the register. However, in Article 28, the law also provides for the reinstatement of the cadre's name into the register after successful completion of the punishment period and payment of a prescribed fee (Allied Health Professionals Council, 2000).

Table 20: Fees structure for registration and licensing doctors in Uganda

FEE CATEGORY	REGISTRATION STATUS	RATE
ORDINARY FEES		
Provisional Registration-Once	Ugandans	50,000
	Non Ugandans	$100
Full Registration-Once	Ugandans	100,000
Specialist Registration-Once	Post Graduate Degree or Equivalent	100,000
Additional Qualification-Once	post graduate training	75,000
Annual Practicing License	All Registered Practitioners -Generalists	100,000
Annual Practicing licence	All Registered Practitioners -Specialists	200,000
Certificate of Good Standing	All Categories	100,000
Retention on Register Fees (For Ugandan Doctors practicing outside Uganda)	Ugandans	100,000
Pre - Registration Examinations (MLEB)	Ugandans	$ 200
	Non Ugandans	$500
Temporary Registration (up to 12 Months)	Non Ugandans in the Public Sector	$200
	Renewal	$ 100
Temporary Registration (up to 12 Months)	Non Ugandans in the Private Sector and NGOs	$ 400
	Renewal	$ 200
FINES		
Practicing without Valid License Fine	Ugandans	500,000
	Non Ugandans	$ 500
Investigation / Medical Inquiry fees (Paid only if found guilty of Misconduct)	All practitioners	50 % of Total investigation cost
Punitive Fines (Imposed on Doctors and or their Health Units found guilty of Misconduct)	All practitioners	Up to 3,000,000
	Health Units	Up to 3,000,000

Source: Uganda Medical and Dental Practitioners Council – https://umdpc.com/Resources/FEES%20STRUCTURE.pdf

Furthermore, key informant interviews indicated that regulatory relationships post-conflict were of a friendly nature compared to during the conflict period. Specifically, at the time of data collection, the regulators noted that they interacted freely with those they regulated. The study also found a role conflict involving one of the regulators, who, despite the regulatory responsibilities they held, also owned a clinic within the same area. It was therefore interesting to note that during interviews, the regulators in Gulu were more articulate about the challenges faced by the FPFPs and then, in the course of the interviews, put on their 'regulator hats'.

7.2.3 Partnerships with the district/ government

The study found that the FPFPs were in partnership with the district office and other government institutions, such the Uganda Revenue Authority (URA), the Pharmaceutical Society of Uganda and Gulu University. The partnership with the district office enabled the FPFPs to receive resources such as the Primary Health Care (PHC) grant, vaccines for immunisation, and family planning supplies. In relation to the provision of PHC and vaccines, the district officials indicated that the FPFPs were expected to conduct immunisation and submit reports. Interestingly, only one FPFP mentioned that they submitted reports to the district.

Other benefits of the partnership with the district included training in self-regulation, cold chain management and support in tax management, waste management and health camps. Further analysis revealed that FPFPs that had been in business for some time (over 10 years) benefited more from these privileges than their counterparts who had set up business after the conflict.

7.2.4 Partnerships with NGOs

The FPFPs were also in partnership with several NGOs working around Gulu whose modus operandi was based on a written agreement, commonly referred to as a memorandum of understanding (MOU). The partnerships were established based on a manager approaching the NGO to discuss the possibility of working together or vice versa. The benefits of such partnerships included support for HIV testing and diagnostics, the expansion of service coverage through outreach and health camps

as well as training of health workforce particularly in reproductive health and family planning as well as drug display. The most influential NGOs are shown in table 21.

Table 21: Some influential NGOs in the network of FPFPs

Name of NGO partner	Partnership
NuHITES	Support with HIV diagnostics
GWED-G	Tests to communities
PACE	Family planning support, training in drug display – for drug shops
Health for Them	Health camps
PROFAM	Support for family planning
Reproductive Health Uganda	Referrals
Watoto Ministries	Tests and health camps

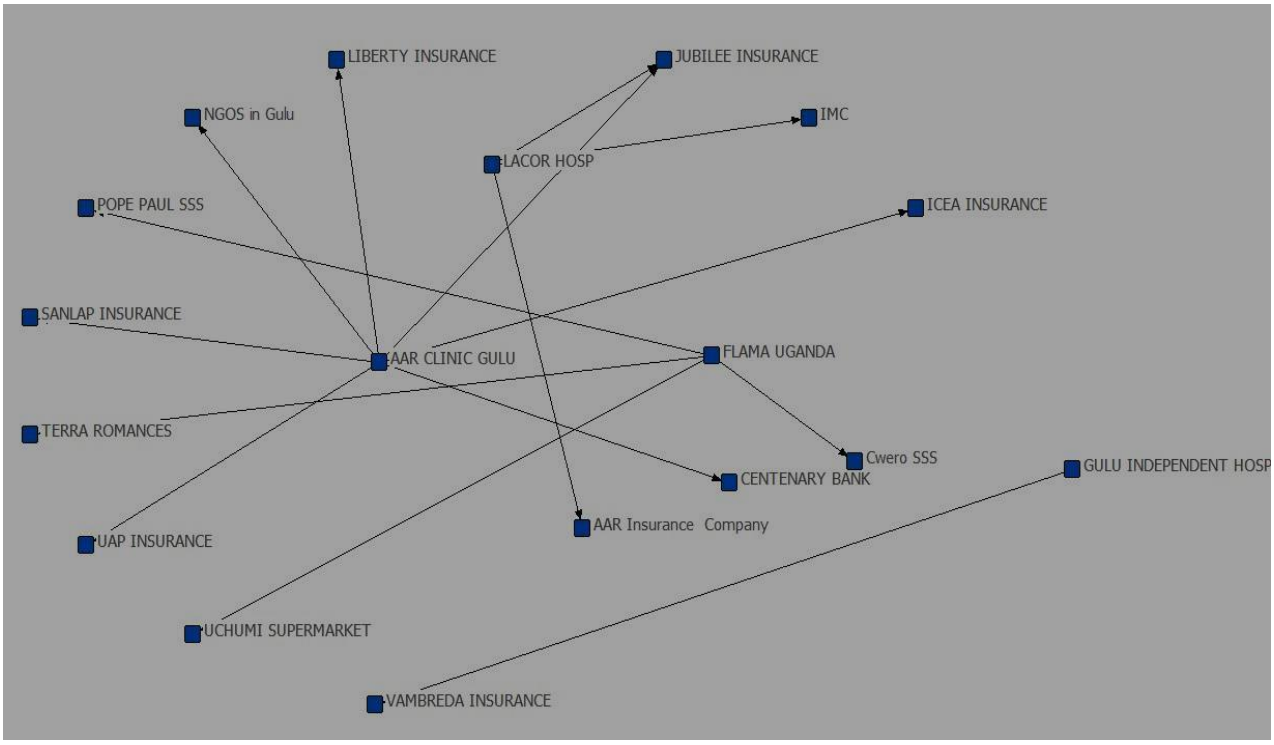
7.2.5 Health maintenance organisations (HMOs)

Health maintenance organisations (HMOs) provide health coverage for an annual fee. There were several insurance companies which were reported to have clients in the municipality. However, many except two, were non-facility-based and hence utilised a network of facilities in the municipality to provide health services to their clients. As indicated in Figure 33, the facilities utilised by the HMO network mainly comprised the three well-established hospitals in the district, including the private for-profit hospital, the mission hospital, and the public hospital. One of the insurance company clinics seemed quite popular, as it provided services for non-medical organisations such as the UCUMI supermarket and banks as well as clients of other insurance companies which operated in the area but lacked a physical health infrastructure. In cases where the insurance company clinic was unable to offer services, particularly in complicated cases, it would sub-contract the three hospitals mentioned earlier to provide services on its behalf while it retained the role of managing payments. The manager of the said insurance company clinic boasted of making huge profits.

> We also have an MOU that we would treat their clients for a number of insurance companies that do not have their medical setting […] those give us about 25 million Uganda shillings a month. (P15: LH_Insurance company clinic _ Young FPFP)

Accordingly, Figure 33 illustrates that one insurance company clinic is central and important in the network because it provides services to clients of other insurance companies, which are indicated within the network, as well as employees of NGOs and banks. One private health centre II was providing services to students in two secondary schools and staff of a supermarket and an NGO. Based on the interviews, Gulu Independent Hospital had previously been providing services to clients of various insurance companies. However, by the time of fieldwork, all MOUs had expired, and it was only providing services to clients of Vamrenda Insurance. This link is indicated in Figure 33.

Figure 33: Networks for health maintenance organisations



7.2.6 Drug procurement

Drugs are a key input to any health business at whatever level, hence relational links of drug procurement and drug supply existed for FPFPs and pharmacies as well as pharmaceutical companies. The study found that during the conflict, the choice of pharmacies was limited, whereas the relative post-conflict peace created an opportunity for more pharmacies to open up and hence increased the scope of sources from which FPFPs procured their drugs within the municipality. The study found that post-conflict, pharmaceutical companies from Kampala flooded the market and started advertising their products. Some pharmaceutical companies even reportedly implemented innovations such as delivering drugs at the doorsteps of the FPFPs, hence indirectly saving managers the trouble of travelling to Kampala to purchase drugs.

7.2.7 HR sharing and borrowing

The study found that sharing of the health workforce occurred between FPFPs and fellow FPFPs as well as between FPFPs and non-FPFP facilities such as Gulu University. Three of the 10 cases interviewed for a life history experienced sharing of staff with FPFPs beyond the municipality boundaries. The managers of the FPFPs interviewed perceived sharing of staff as a way of coping with the high costs of paying for experienced cadres as well as filling the vacuum created by the absence of some staff during the peak hours. One of the managers referred to the latter as *'borrowing staff'*.

> We have been borrowing medical doctors from the clinics. For instance, the medical officer or CO would come and leave at midday, and there is no one to replace and maybe I know somebody somewhere and I call that somebody may be working in victory Medical centre. (P18: LH_ Medical centre _ Old FPFP)

In instances where staff were shared with non-FPFPs, they mainly came from the public sector and this, although not exclusively, was common with specialised cadres. Certain policies of managing the workload in the public sector, such as working in shifts to ensure flexible schedules for health workers in public facilities, created an opportunity for health workers to juggle work in the public sector and in the FPFPs during the periods they were indicated as being off duty. This could be either during the day or late in the evening. These staff could easily be part of the pool to be *'shared/borrowed'* by FPFPs and enable the FPFPs to cope with the high cost of salaries.

> When you are in private practice and you employ someone, who is in government service, part of the burden to satisfy that person has been taken by the government. Now if you are going to keep him as the sole employer then you are going to raise that bill yourself. (P2: KI_ Manager Public facility)

7.3 Discussion

Chapter 7 has shown that FPFPs have a dense network with other organisations within the market in which they operate. A network indicates an accumulation of links between individuals or organisations (McPake and Normand, 2008). The networks in this chapter have been illustrated by the network maps indicating the relational links involving each organisation. McPake and Normand (2008) further note that networks act as an alternative way of organizing transactions. They reflect not only the market

structure, but also the organisations reputation and, from an NIE perspective, some level of trust between organisations.

Furthermore, Gilson et al. (2017) emphasize that ‘relationships and social networks within the health system underpin everyday resilience’. From an NIE perspective, the emergence of networks could be interpreted as a coping strategy, where FPFPs attempt to move from hierarchical to market modes of transacting in order to economize on transaction costs (McPake et al., 2013:152). For example, FPFPs indicated that amidst the high operational costs and the challenges faced in hiring full-time staff, they took advantage of a public workforce that needed more income, which is a neo-liberal tactic facilitated by shift work in the public sector. The emerging social networks illustrated in this chapter were considerably important in strengthening the presence and participation of FPFPs in the health market in the area. For instance, they provided an opportunity for some to contribute to the expansion of service coverage and referral. Most of the relational links indicated an exchange of resources without necessarily paying with money, which reinforces the NIE assumption that organisations can help co-ordinate markets.

The relational links also illustrate the blurry nature of boundaries between FPFPs and other organisations. This reinforces the evidence and arguments about the distinctions between the public and the private sector (Whyte, 1992, Guisti et al., 1997) and the fluid nature of the boundaries between the two sectors, which enables ‘free circulation’ of resources (Birungi et al., 2001).

The chapter has also shown that relationships between FPFPs and other organisations were based on both formal and informal contracts and agreements. Within NIE, these contracts enable the coordination of transactions by providing for

the creation of formal or informal rules. According to McPake and Normand (2008), formal contracts can be explicitly written and legally binding agreements but can also be implicit. Milgrom and Roberts (1992) in McPake and Normand (2008) define implicit contracts as ‘a shared understanding that is not legally enforceable but that parties consider to be binding on one another’s conduct. These contracts were common among FPFPs. For instance, the provision of loan books by the smaller FPFPs and the contracts between managers of the FPFPs and those they contracted to supervise their facilities in order to beat the strict regulation are reflective of the informal category defined by Milgrom and Roberts (1992).

Furthermore, within the new institutional economics, contracts present a new mode of conducting an exchange. However, Williamson (1985) in McPake and Normand (2008) describes two challenges that arise with contracts – bounded rationality and opportunism (p.132) – which have already been explained in Chapter 2. This implies that contracts can present difficulties and some of the challenges reported by business managers in relation to ‘supervisors’ wanting to increase the fee for acting as quasi-partners reflect this aspect really well.

Lastly, the chapter has also highlighted the central role that FPFPs play in the health market, including participation in referrals, the expansion of service coverage, the procurement of drugs and equipment as well as health maintenance of clients, particularly with the emergence of insurance companies.

The chapter has shown that referrals are a main relationship within the network and market in which the FPFPs operated. Indeed, the literature indicates that referral is one of the key relationships between the public and the private sectors (Birungi et al., 2001, Gautham et al., 2014). The available literature within the ReBUILD Consortium

indicated that the private not-for-profit organisations play a major role in supporting health service delivery in the Acholi sub-region (Namakula et al., 2016). The network maps indicated that FPFPs not only referred clients to the public but also to private not-for-profit facilities and highlighted the special position of the private sector within the health system in such a setting. Some categories of FPFPs, e.g. the X-ray centre, the stand-alone clinical laboratory and pharmacies, acted as middlemen in the treatment cascade. For example, a patient at public facility A would be referred to pharmacy X for drugs and then return to the facility for treatment. Nevertheless, these FPFPs were in some cases the last place of reference. However, the chapter has shown that referrals between public facilities and FPFPs, which were characterised by perceived mistrust and envy, could be a starting point for a discussion of the public-private partnership for health.

A unique contribution of this chapter, however, is the information about other relational links, including those around HR, and regulatory relationships, among others, and the evidence that, indeed, transactions between organisations may not necessarily require money.

CHAPTER 8: MECHANISMS BY FPFPS TO ENSURE PRO-POOR ACCESS

8.0. Introduction

This chapter addresses the third research question of this study, which sought to understand the mechanisms employed by FPFPs to ensure pro-poor access. The chapter draws upon both quantitative (organisational survey) and qualitative methods (life-history interviews and key informant interviews). While analyzing this data, the researcher reflected on the neo-liberal assumption of profit maximization while also highlighting aspects of social entrepreneurship theory.

First, the chapter explores the FPFP managers' perceptions of the poor and presents some parameters that guide the identification of the poor as innovated by the managers. Thereafter, the mechanisms that the FPFPs employed to show that they 'care for the poor' are presented, with corresponding justifications indicated, where applicable. Lastly, a concluding discussion of the chapter is presented.

8.1. How Do the FPFPs Identify/Define a 'Poor' Person?

The interviews explored the concept of poverty, particularly how poverty relates to care-seeking in FPFP providers. The researchers first explored how FPFPs defined the poor. According to some participants, the 'poor' could be defined based on five main parameters, which were determined mainly by the manager of the for-profit business. These included the following:

i) Appearance

In terms of 'presentation/appearance', a poor person is defined as one who is either 'not well dressed' or 'not clean'. One of the managers (a regulator who

owns a clinic within Gulu) claimed to be able to distinguish a rich person from a poor person even if they are both dirty.

> […] if someone is not well dressed […] (P1: KI_Manager_Other FPFP_ facility)
> That skin [for a rich person] will still shine even if [covered] in the dust; yes, even if very dirty today we can know that this one here. So, we give them a bill and they say I cannot afford five thousand and say I have only three thousand shillings only, but I will see you […]. (P9: KI_ Regulator_ District level)

ii) Perceived inability to pay bills

A person's inability to pay the bill was evaluated, based on the managers' empathetic feelings generated after listening to the client's explanations regarding failure to pay and the observation that the person had been 'stranded' at the facility owing to non-payment of bills. A poor person was one who said they were unable to pay even a bill perceived to be small or one that affirmed that they found it difficult to cover the bill for a service offered. Mothers were more likely to take on the caregiving role at the facility or take the patients to the FPFP facilities.

> Yes, when a mother comes you can see for yourself that she as only two thousand [shillings- [equivalent of about half a dollar based on the 2015 exchange rates] you do the laboratory test. […] and if you see that the child has malaria now, she will tell you now I do not have the money. (P1: KI_ manager, Other FPFP facility)

iii) Perceived level of politeness

The polite way to ask for favours that was employed by some clients as they requested *an exemption or fee reduction* qualified them as 'poor'. Politeness was judged based on the words and tone used by clients. Those with a perceived high politeness level were perceived to be poor and the arrogant ones were perceived to be rich.

> […] the way they [patients] will talk to you, you will know. So, you do not need too much psychology, you will know this one has nothing, but this other one can pay. They [poor people] are usually very polite even in the way they ask […] But there are some people who have money and they will start talking to you with arrogance. (P19: LH_ medical consulting and X-ray_ Young FPFP)

iv) Place of residence

For some FPFP managers, a poor person was perceived as someone whose place of residence was located a long distance from Gulu town (rural Gulu). Such participants also seemed to imply that medical personnel were gifted with an extraordinary skill of identifying people who have travelled long distances so as to access the services in Gulu town.

> You ask the patient to pay 2,000 shillings- [50 US cents] […] and he tells you he does not have money […] he starts pleading with you that I came from Ngai, or Opit village and just walked to Gulu town, I am really sick or my baby is really sick. Therefore, you can see that if you do not help, they will probably have to walk back to Opit village without being treated or offered services. (P18: LH_ Medical centre_ Old FPFP)

V) Use of coins to pay for services

According to one of the managers, clients who use coins are perceived as poor. This is because of the perceived difficulty related to the process of accumulating and counting coins of a certain amount to be able to pay a medical bill.

> […] and gives you coins not notes, you must know the person has no money. (P20: LH_ Clinical laboratory Young FPFP)

8.2 Mechanisms Employed by FPFPs to Enable Pro-Poor Access to Health Services

The interviews explored how FPFP providers approached or tried to show that they cared for the poor and the reasons why. Various mechanisms were employed by FPFPs to enable the poor to access health services in Gulu municipality. These included the provision of free services, fee reduction and top-up of fees and payment of services in-house/outside the FPFP facility. There were also some flexibility and

practices around ensuring that payments were *'manageable for clients*. These included loans, fractions/partial doses, and payment in instalments. The mechanisms are explained in detail below:

8.2.1 Provision of free services and fee exemptions by FPFPS

Although the FPFPs are largely believed to be for-profit, the researcher asked the question to test the theory that FPFPs cannot offer any fee exemptions. As indicated in Table 22, all the 45 FPFPs interviewed except pharmacies, laboratories, private hospitals, and insurance company clinics, reported that they offered some fee exemptions. However, fee exemptions were most likely to be offered in clinics or medical centres than in other categories of facility.

Table 22: FPFPs likely to offer a fee exemption

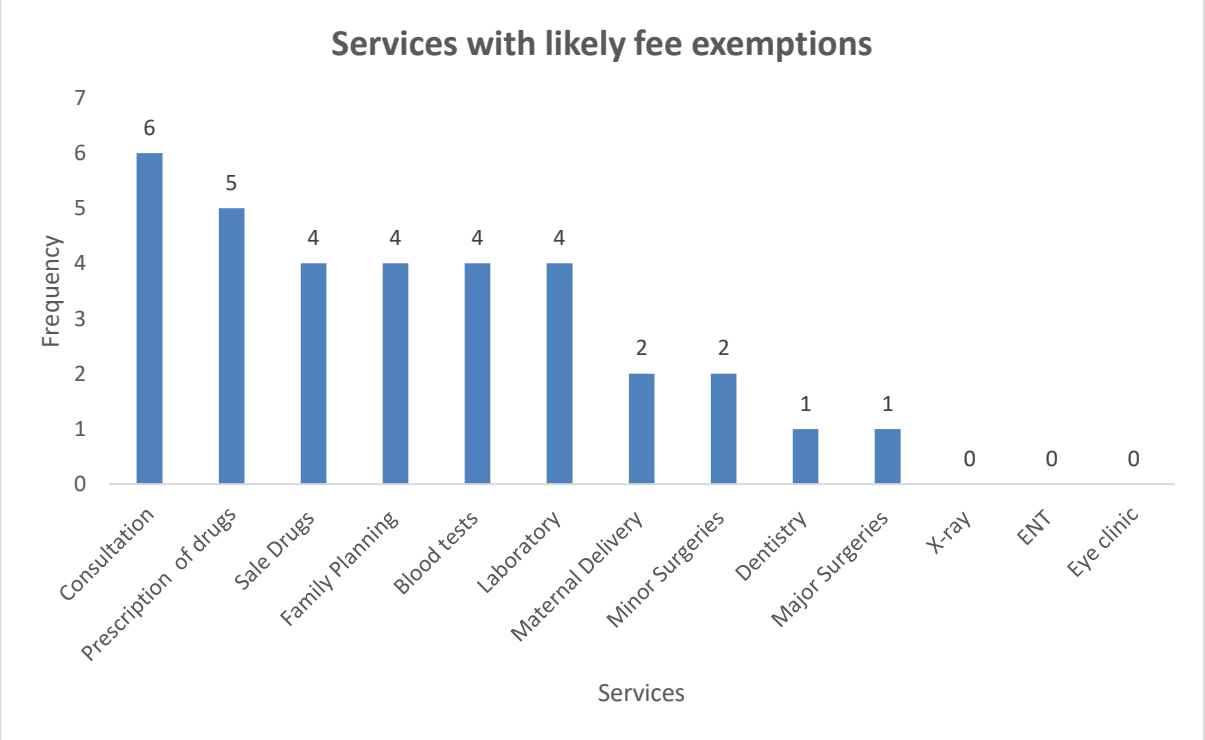
Q114Do you have a fee exemption?			
Category of organisation	**Yes**	**No**	**Total**
Clinic	6	12	18
Medical centre	3	4	7
Pharmacy	0	5	5
Laboratory	0	2	2
Private hospital	0	1	1
Insurance company clinic	0	1	1
NGO clinic	1	0	1
Drug shop	2	6	8
X-ray and scan centre	0	1	1
HC II	1	0	1
Total	**13**	**32**	**45**

The categories exempted included the elderly, child mothers, adolescents, women within childbearing age (pregnant women) and people with disabilities (PWDs).

Services for which fee exemptions are likely to apply within FPFPs

Figure 34 shows that fee exemptions were likely to apply to all services except X-ray, Ear Nose and Throat (ENT) and eye clinic. In descending order, the services for which fee exemptions were likely to apply included consultation, prescription of drugs, sale of drugs, family planning and laboratory services. Fee exemptions were least likely to apply to services such as major surgeries, minor surgeries, maternal deliveries, and dental services.

Figure 34: Services with likely fee exemptions



Services with exemptions

In addition to those services indicated in Figure 34, qualitative interviews with managers indicated that other services which were provided for free by FPFPs included immunisation of children, family planning, HIV testing, screening for hepatitis B, diabetes screening and blood transfusion.

8.2.1.1. Reasons why FPFPs offer free service

Partnerships: The interviews explored the reasons why FPFPs provided free services. The study found that one of the factors that enabled this was partnerships with governmental and non-governmental agencies as well as partnerships with some selected educational institutions within Gulu municipality. FPFPs reported that they were able to provide free immunisation services as it is an area of coverage targeted by the public sector. This was enabled by government subsidies in the form of vaccines, fridges for storage and primary healthcare. A few well-established and larger FPFPs, particularly hospitals and insurance company clinics, were thus able to provide free services. In return, such FPFPs were expected to submit reports to the district offices.

> […] we get the vaccines from the district and we do UNEPI [immunisation] here and then we give the district the report […]. (P15: LH_ Insurance company clinic_ Young FPFP)

Partnerships with NGOs and other FPFPs, and MOUs with academic institutions enabled FPFPs to conduct health camps during which they undertook the provision of services such as free blood pressure checks, free hepatitis-B screening, free cancer screening and family planning. These partnerships were reported to be because of lobbying by managers of the individual FPFPs, as in the case of one insurance company clinic.

Free services as an advertisement: In most cases, free services were perceived as advertisements for other services in an FPFP facility. For instance, when mothers came for free immunisation, they would be informed about other paediatric-related

services. Free consultation and blood transfusion were provided mainly by small and large FPFPs, respectively, with the aim of encouraging prospective clients to seek services.

> Then we have other free services like blood transfusion […] but they are not going to get blood only, they are going to get other treatments and we shall charge for the sets used to administer the blood and all treatments. If we find that you also have malaria, we are giving you anti- malarial[tablets] which are not for free. (P4: KI_HW other FPFP facility)

To avoid wasting vaccines: One of the deviant cases was a manager who explained that their facility provided free services, for instance vaccinations, simply because they wanted to get rid of reagents that were about to expire.

8.2.2 Price reduction and bargaining

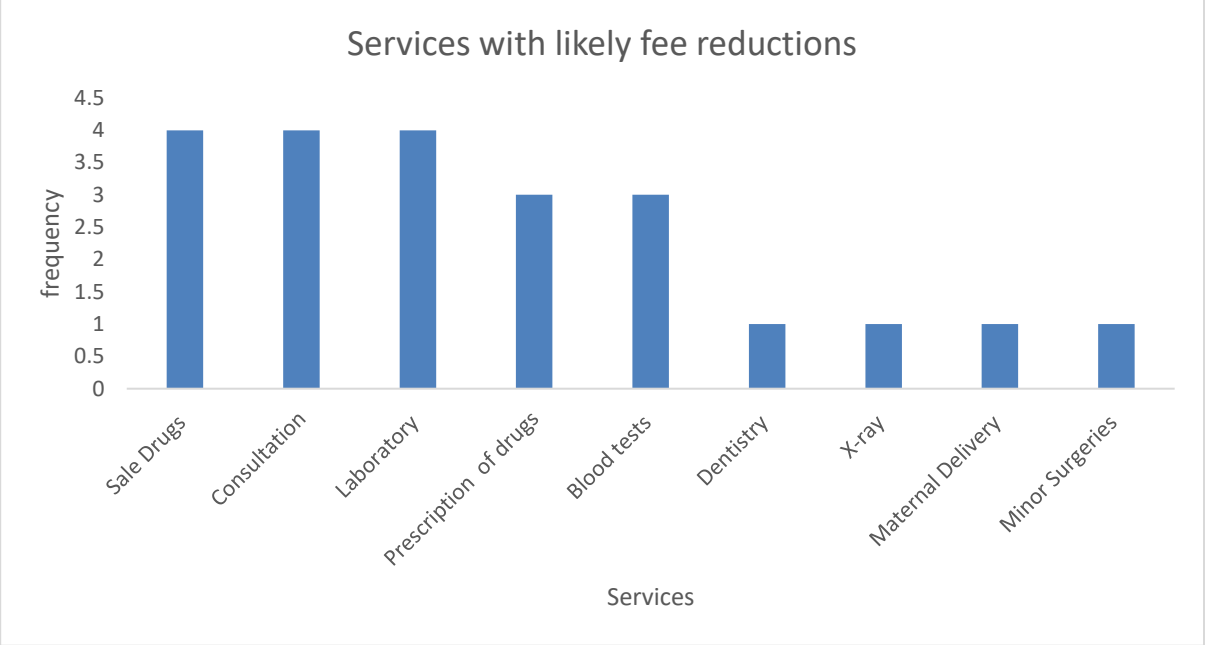
Price reduction was another mechanism employed by FPFPs. The study found that FPFPs were likely to offer price reductions for all services except for major surgeries, ENT, laboratory and family planning. The services with the lowest likelihood for fee reductions included dental services, X-ray, maternal deliveries and minor surgeries. Services such as sale of drugs, consultation and the prescription of drugs, blood tests and laboratory tests were reported to have the highest likelihood for fee reductions.

Categories of clients for whom fee reductions are offered

Results showed that none of the FPFPs was likely to offer fee reductions to former abductees. However, some FPFPs would mostly offer fee reductions to the elderly (7), adolescents (5), Persons with disabilities (PWDs) (3), Persons Living with HIV/AIDS(PLWHAs) (3) and child mothers (3). An equal number of FPFPs (3),

although still low, reported that they would offer fee reductions to pregnant women and all households in Gulu. Only one FPFP reported that they would offer fee reductions to NGO staff. However, some FPFPs also reported that they would offer fee reductions to other categories of clients, particularly regular customers and uninsured patients, needy women and 'those who cannot afford'. Figure 35 shows that only nine out of 14 services offered had the possibility to reduce fees.

Figure 35: Services with likely fee reduction



Price discrimination: Some FPFPs practiced price discrimination by reducing the price for the person perceived to be poor and increasing the price for the person perceived to be rich to make up for the shortfall. For instance, a manager of one of the insurance company clinics reported reducing the price for those clients who were not under insurance cover while making the bill higher for those covered by insurance.

However, qualitative interviews revealed that in the event of price reduction, FPFPs ensured they still made some profit, although some intended to maintain clients by using the ploy of *reducing* the prices for them.

> […] usually people bargain, and we reduce. For example, ultrasound scan is at 25,000/= ($6.63), there is some negotiation that 'Doctor, I have 20,000/= ($5.30)'. We say okay, pay that and they feel happy […] and you maintain a relationship with them because they say, the doctor reduced the price for me [laughter]. If I tell them this is that there is no reduction, I realise I am being rude. (P2: KI_Manager Public Facility)

Furthermore, some managers of the FPFP facilities were hesitant to publicize price reductions to minimize the chances of such incidents happening.

> But we do not publicize that, we just do it quietly, otherwise even those with money will come and say that 'we are being discriminated'. (P1: KI_ Manager Other FPFP Facility)

> Normally, I would take the person aside, because you know we do not want to make people think that it is common for us to [actually] reduce the prices. (P15: LH_ Insurance company clinic_Young FPFP)

In one of the cases, price reductions emerged from a bargaining process between the manager and a client/patient. Bargaining was perceived to create a 'win-win' scenario for both the manager and the patient. For instance, one haggled for the cost of an operation for a medical condition and noted that in the end, the patient went away with the satisfaction that they had had a fair bargain, although the provider still got the expected price.

> We have the advantage that we know more about the [operation] procedure than the patient […], so if I tell you one million ($300), because it is a complicated procedure. Because you have the confidence in me, someone will say I have 800,000/= ($250) then I say 900,000/= ($280), you can pay that [laughter]. (P2: KI_Manager Public Facility)

8.2.3 Loan books and deferred payments

Loan books were common among 'small' providers as a strategy for dealing with competition with 'big' providers who have a greater market share. Loan books enabled the client to pay later hence, reduced the burden/inconvenience on the client of paying the whole fee at once. However, trust emerged as a key factor in the

operationalisation of the loan books. The presence of the manager was an enabler for decisions for loans or deferred payments to be made. The loan book was also mainly an agreement between the manager and the client to whom the loan was given.

> […] we can give you your full dose, but you make a commitment to pay. For example, that woman you saw, we are giving her treatment for her child, and she has a loan book here. She can pay later […] (P4: KI_ Health Worker_ Other FPFP Clinic)

8.2.4 Unbundling services/medicines

Unbundling services/medicines was a practice used by the FPFPs to motivate those who could not afford to pay for the full dose at once. This was particularly common for malaria doses and among smaller FPFPs. Under this arrangement, a client would be given a portion of the dose that they could afford on the assumption that they would come back the next day with money for the next dose. One of the managers in a public facility who also owned a clinic elsewhere reflected on his experience at his clinic.

> […] Now if it is an outpatient, and the patient says that 'I only came with, say 50,000 shillings', we tell them that the dose is incomplete, it is supposed to be for seven days. Buy. We have given you for two days because of the money you have. You can come back for the remaining part of the dose when you get the rest of the money […] there are some who go and don't come back and they will not heal because of the incomplete doses but I would not have lost money. (P2: KI_Manager Public facility)

8.3 Discussion

Chapter 8 has focused on the mechanisms employed by FPFPS to ensure relevance to the pro-poor agenda. The chapter contributes to the ongoing debate about whether the private sector, particularly for-profit organisations, should or should not be

engaged in efforts to achieve UHC. The chapter also provides evidence to test the hypothesis ‘whether or not the private sector can be pro-poor’.

The chapter has shown that FPFPs would like to maintain a good image among the public by ensuring that they enable access to healthcare services by the poor. However, they continuously face a dilemma of balancing the optimization of their incomes with the altruism objectives.

The chapter has shown that FPFPs implemented various mechanisms to ensure that the poor could access healthcare. These mechanisms, according to the social entrepreneurial theory (Abu-Saifan, 2012), provide evidence that the FPFPs have the potential to swing between making profit and acting for a social value, hence acting as social entrepreneurs.

The chapter has shown that the implementation of any equity mechanism requires some measures of identification of the poor involving about five parameters which were unsystematically applied by managers. However, owing to the unsystematic nature of applying the parameters, the absence and the mood of the manager, some of the very poor are likely to miss out on the opportunity to qualify for the free services or a reduction in price. There is, therefore, a need for a more systematic way of identifying the poor within the for-profit providers (Patouillard et al., 2007).

Ironically, the mechanisms were not meant to be advertised (made known) and the operationalisation of some mechanisms, for instance, fee exemptions and bargaining for fee reductions, reflected a dilemma that managers were facing to move along the extreme continuum of social entrepreneurship.

Some of the mechanisms enabled a reduction in the financial burden that would result from the clients paying at one go while some flexibility and practices ensured that payments were manageable for clients. These included loans, fractions/partial doses and payment in instalments. Furthermore, some of these mechanisms are not necessarily unique to post-conflict settings but similar to those found in some studies conducted among informal providers in relatively stable contexts such as India and Bangladesh (Bloom et al., 2011).

The dilemma was further reflected through actions undertaken by FPFPs to ensure that they leveraged the opportunity made available by the provision of free services, which was enabled by partnerships with other sectors, to market the other services that they provided in-house. Furthermore, the chapter has shown that the package of services that were picked out for fee exemptions was narrow, and mainly focused on prevention. The price exemptions within FPFPs, therefore, leave a lot to be desired, given that some of the most critical services, such as diagnostic services, are not exempted. In terms of UHC, there is need for a more comprehensive and clearer package of service.

Unlike the young FPFPs, the older FPFPs were more likely to provide free services through partnerships with government agencies and with NGOs. From the NIE perspective, this reflects rewards for credible commitment, which may later have enabled the FPFPs to undertake complex contracting and transactions that would otherwise have been difficult, and hence ensured their continuous survival in business (North, 1994). The older FPFPs showed credible commitment through investing in infrastructure; such commitment was also reflected through being able to conduct business and provide health services for a long time, even during conflict,

and thereby being able to negotiate for support from the district offices and attract partnerships for the exchange of various resources in the early post-conflict period. This evidence further supports the assertion that organisations are agents of change in an economy and that their bargaining power and perceived effectiveness over time, as a result of changes in their relative success in accomplishing their objectives, can influence alterations in the institutional framework (North, 1994).

The majority of FPFPs implemented fee reductions, mainly resulting from negotiations between the client and the provider. Beyond prices, NIE recommends bargaining as a means of determining price, hence again going beyond the neo-classical economic assumption of prices being determined by only forces of demand and supply. Evidence emerged from this study that negotiation has limitations since some managers reported exaggerating the price of treatment. This finding points to greed and the need to maximize profit, which is one of the assumptions of the neo-liberal theory, and further reflects the NIE-related concept of information asymmetry (McPake et al., 2013), which is one of the challenges with the demand for healthcare. As noted in Chapter 2, information asymmetry is a situation where one party in a transaction has more information than the other. In this case, the doctor has more information than the patient and takes advantage of this situation (McPake and Normand, 2008, McPake et al., 2013). Such a scenario further implies that the doctor has misused his position as an agent and highlights the need for oversight by professional bodies (ibid.). In this study, one of the managers lied about the actual condition of the patient and used this lie as a ploy to bargain for the price of the operation with the client.

Some FPFPs practiced unbundling of services, where the clients would be given doses that they could afford with the hope that they would return. This situation leads to a dilemma. On the one hand, it helps reduce catastrophic expenditure by breaking down the burden of OOP over a period. However, this has implications for quality, which is reflected through drug resistance, particularly when the clients fail to return to complete their dose. The concern about quality of services in the for-profit sector in relation to breaking down doses has also been highlighted elsewhere (Bloom et al., 2011).

Unbundling of services and extending loans were based on trust, which, as indicated earlier, is a key concept of NIE (Dequech, 2005). Trust reflects a 'social-contractual relationship' between the providers and the clients, as indicated by Bloom and colleagues (Bloom et al., 2008). Trust is important for the effective performance of health systems, given that it creates a feeling of satisfaction in connection with both clients' needs/expectations and providers' expectations (Gilson, 2003, Bloom et al., 2008). Another study conducted earlier on the private sector in the conflict-affected region of Northern Africa also found trust to be an important aspect of business (World Bank, 2005).

CHAPTER 9: DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

9.0. Introduction

The key findings of this study have been presented in the previous chapters – Chapters 5 to 8. This chapter begins with a summary of the contributions of this study. The researcher also presents her reflection upon the initial conceptual framework, which was conceived earlier, in relation to the study findings, and highlights areas for emphasis and new developments arising from the study findings. Consequently, an empirically derived conceptual framework is presented. The main findings of the study which relate to private sector characteristics, resilience, and the extent of the contribution of FPFPs to UHC are then discussed in the light of the existing literature. The researcher simultaneously reflects upon patterns of behaviour observed in private providers that are particularly characteristic of post-conflict settings, while noting, where possible, the outstanding similarities with settings that are relatively stable. The researcher then reflects on the limitations as well as the strengths of the study. The conclusions and recommendations based on the empirical findings are also presented. Lastly, the researcher summarises areas for further research and action.

9.1 Main Contributions of This Study

The overall objective of this study was to understand the extent to which FPFPs have contributed to building an equitable/pro-poor health system in Northern Uganda. This study was important owing to the limited body of evidence on the FPFP sector in general and on conflict/post-conflict settings. The study makes a contextual contribution, in that it provides knowledge about how conflict affects the FPFP sector's contributions over time as well as the aspects of resilience and strategies for

benefiting from opportunities presented in the post-conflict period. The study provides insights into how FPFPs get established and survive, and identifies the innovations used to cope with conflict and business strategies in relation to the challenges encountered in the post-conflict period.

Furthermore, the study provides evidence about innovations devised by FPFPs to gain social acceptability and to contribute to the advancement of UHC goals. Despite the dilemmas highlighted in relation to balancing the latter with the for-profit objective, this can also be perceived as a contribution to the *know-how* knowledge type, which presents guidance on local operational knowledge about good practices by the formal for-profit private providers (Bennett et al., 2014). The information about relational networks singles out the key FPFPs within the networks of health service delivery in Northern Uganda and provides learning about the possible set of interactions (Bennett et al., 2014) that may occur among the actors in the healthcare market. In addition, the networks illustrate some areas, for instance referrals, health maintenance and diagnostics, where FPFPs play central roles. This evidence can, therefore, be a useful resource for informing the development of programmes for the engagement of the FPFP sector or for strengthening the implementation of the public-private partnership for health (PPPH) in Uganda.

There is limited documentation about innovative ways of acquiring data from private health providers in order to capture the complex dynamics present within health markets (Bennett et al., 2014). Using a range of mixed methods, this study makes a methodological contribution to studying a complex phenomenon, understanding the experiences of FPFPs across post-conflict phases as well as the healthcare market.

In particular, the use of the life-history method allowed the providers to narrate their experiences, hence providing them with an opportunity to contribute to tacit local knowledge about the dynamics of the market. Furthermore, the use of the life-history method enabled retrospective interrogation as well as an understanding of the changes/evolution of the FPFPs over time and their survival/resilience across conflict phases. Literature about the use of the life-history method to study such organisations in conflict-affected settings and even in relatively 'stable' settings is limited. Additionally, social network analysis was used to illustrate the relationships between FPFPs and other organisations in the area. Whereas documentation about these linkages in the market has been in existence, this is the first time that SNA has been used to graphically illustrate such linkages.

The study also makes a theoretical contribution by providing an understanding of the factors that enable transactions beyond the forces of demand and supply, for instance, non-price mechanisms such as organisations and networks. This is because the study utilised the NIE theory to inform data analysis.

9.2. Reflection upon the Conceptual Framework

The conceptual framework (Figure 9) introduced in Chapter 3 was developed by the researcher prior to data collection and was mainly based on the existing literature. Within this framework, the researcher outlined the factors that were expected to influence the contribution of the FPFPs to building equitable health systems in post-conflict settings. The assumption was that the broader contextual factors on the left column of the conceptual framework – EC1 – would influence changes/adaptations within the FPFPs- IC. The organisational factors related to the characteristics of FPFPs (at the centre of the framework – IC) and the adaptations brought about by factors in the broader context as well as factors within the policy levers that feature in

the right column of the conceptual framework – EC2. The policy levers illustrated controls by the government in relation to regulation, health workforce recruitment, management and incentives that have influenced the establishment of and adaptations within FPFPs. For instance, the study findings indicated that under column EC2, professional bodies such as the Uganda Medical and Dental Practitioners' Council, the Allied Health Professionals, Uganda Nurses and Midwives Council, Private Midwives Association of Uganda and the Pharmaceutical Society of Uganda provided the national institutional context and rules for establishment and operational conduct, among others, with which FPFPs were expected to strictly comply.

At district level, the office of the district health office enforced the norms at national level through supervision. The municipal council levied annual tax fees and ensured that fees paid were appropriate for the size of business and size of signposts. The findings also showed that in some ways, changes within the organizational characteristics created response in the EC2 column. A case in point was when the key informants reported that the government had initiated laws about the number of FPFPs expected on a given street and the standard distance of 60 metres that must be between the different facilities.

Initially, the researcher assumed that all the factors indicated in the conceptual framework would prove to be significant, that the conceptual framework was exhaustive including all potential factors, and that the relationships between the factors listed were obvious and straightforward. However, from analysis of the all the information collated from the key informant interviews, life histories and organisational

survey, the researcher realised that first, not all factors that influenced the contribution of the FPFPs had been captured in the conceptual framework. Secondly, that there exist inter-connections between some factors. Thirdly, the effect of the different factors and their influence on the contribution of FPFPs towards an equitable health system in Northern Uganda vary, although this cannot be easily indicated/illustrated in the conceptual framework. Finally, some factors, such as the amount of profit made and some adaptations in response to regulation/non-compliance with regulations, were more latent and were, therefore, less likely to be discussed by the FPFP managers directly or openly and these could be synthesized at the analysis stage.

For instance, **economic factors**, when viewed within a broader context – EC1 – such as national tax laws and funds provided by donors at the international level, were initially hypothesized to be important influencers of sources of initial capital to establish a business. There was minimal mention of this in the interviews, except for one FPFP manager who stated that they were trying to write a proposal for resource mobilisation as one of the opportunities available in the post-conflict period. Instead, the findings indicated factors at individual level – personal savings and funds pooled by friends (see section 5.1.3 and Table 17) as key economic factors, particularly in relation to establishment of businesses.

Security of the area, another broader contextual factor, had been assumed to be an important factor and evidence from the study supported this assumption. For example, the study found that conflict in the area, whether during or after the conflict, clearly influenced the FPFPs in various ways – from their establishment, through the range of challenges they experienced to the strategies for coping with the challenges.

Contrary to the assumption that the insecure environment created high economic risk (Avis, 2016) and therefore many got too scared to invest their moneys in a volatile setting, there was no mention of this. Similar to previous studies conducted in the region, insecurity resulting from conflict brought about challenges such as risk of abduction for the managers of FPFPs as health workers and raids on their businesses in general and, therefore, brought out resilience aspect of the managers as health workers (Namakula and Witter 2014). The managers innovated to ensure their security as well as survival by masquerading as patients, closing or changing the location of their business. The role of the conflict as a contextual factor and the resilience of workers as well as the private sector have also been emphasized in other studies about fragile settings (Bertone et al., 2018, Namakula and Witter, 2014, Sweeney, 2009). Based on the analysis of the interviews, it became clear that changes in the security situation (also referred to as end of conflict) was a signal to many of those interviewed that they could begin to invest in a business, even though a return to complete stability could not be easily predicted. This is part of the evolution story that research question number 1 sought to explore in this setting. This context is different from that of other parts of Uganda and elsewhere where the FPFPs operate. Security of the area did not only affect internal businesses but also affected some factors in EC 2 (policy levers), particularly the regulation of the private sector by making it limited, which limitation was perceived as flexibility to be enjoyed by the FPFPs.

Demand for services, another EC 1 factor, was assumed to be a major influencer, particularly of the establishment of the FPFPs, and to later shape the package of services provided by the FPFPs. However, the researcher had not anticipated

changes in demand for services and this was revealed later. The findings indicated that the demand for services moved from limited demand or mainly humanitarian demand during the conflict, to growing demand after the conflict, that came from both the population (segmented according to income) as well as other sectors (public and PFNP), and this increasingly led to a heterogeneous FPFP. The end of conflict brought into demand related factors such as population influx, and existence of NGOs that were more complex and, therefore, required additional layers of interpretation which the researcher had not anticipated. For example, a population influx was identified as a demand related factor, which was due to settlement in Gulu during the conflict and the resultant greater urbanisation of the town in the post-conflict periods (Branch, 2013). The existence of NGOs in the immediate post-conflict period created a ready demand and perceived willingness to pay. As shown in Chapter 2, income is a key element among the other determinants of demand (McPake et al. 2013). In connection with this, NGO employees were perceived to have more disposable income, which was reflected in their demand for specialised services and the use of insurance companies to manage their healthcare. These factors were also reported to explain why some FPFPs established businesses.

Ability to pay and demand, which are part of the broader contextual factors – EC1 – interacted with the organisations, such as adaptation within FPFPs, which are in the central column of the framework (IC). These interactions enabled the researcher to observe connections and answers to research question 3 as well as the overall question about contribution to the pro-poor health system. The general perception among the FPFPs interviewed was that, with the exception of the NGO employees indicated earlier, the population living in the area in which FPFPs operated was

characterized largely by people who were poor and vulnerable but in need of health services. This caused the FPFPs to undertake adaptations internally to attract and maintain clients as well as respond to the pro-poor agenda. Chapter 8 illustrated various mechanisms including loan books and price reductions. Furthermore, the finding about the identification of the poor as perceived by the managers of FPFPs/providers contradicts Robert Chambers' argument that the definition of poverty is mostly highly dependent on perception as defined by the poor themselves (Chambers, 1980). The findings indicated that the providers' perception is mostly unsystematic, unpredictable, and unreliable, hence indicating a likelihood of some of the extremely poor people to miss out on the opportunity to benefit from the pro-poor mechanisms and ultimately health services. Hence, some of these highlighted aspects have an influence on the extent to which FPFPs contribute to a pro-poor and equitable health system post-conflict. Therefore, there is need for a more systematic way of identifying the poor within for-profit providers (Patouillard et al., 2007). A systematic review of interventions by the private sector[37] to improve the utilization of quality health services by the poor also acknowledges that, indeed, poverty is difficult to measure (Patouillard et al., 2007). However, Patouillard et al. (2007) also include place of residence[38] among the proxies to measure poverty in absolute and relative terms. They further advise the use of the socioeconomic status (SES) measure, which looks at the distribution of socio-economic benefits among the most disadvantaged groups within a given population (ibid.).

[37] The systematic review mainly focused on interventions for the private sector that are driven by government and non-governmental actors. This study, however, provides information about private sector-led interventions, although some are enabled by partnerships with other actors

[38] As was found in this study

The existence of other providers in the area, which are part of the broader contextual factors (EC 1), was initially assumed as an important factor which mainly influenced competition and, therefore created challenges for the FPFPs to navigate. Indeed, those interviewed expressed concern that one of the main challenges they faced in the post-conflict period was increased competition, which resulted from an increase in the number of other providers. This reflects the evolutionary nature of competition as well as the pluralistic nature of the market in which FPFPs operate, and this is what research question 2 attempted to address. The existence of other providers partly influenced organisational factors (IC), particularly the adaptations within the FPFPs. For instance, some of the managers interviewed attributed post-conflict challenges, such as increased competition, to the perceived increase in the number of other providers in the area. In Chapter 6, managers of existing FPFPs highlighted marketing as a major strategy perceived to be effective to enable them to attract customers, and ultimately intended to enable them to gain a higher market share compared to others and to survive in business. Recollections by some of the managers of the existing businesses interviewed through the life histories indicated premature closure of some FPFPs, and this was attributed to the inability to keep pace with the competition. Competition, therefore, seemed to keep the number of FPFPs in check. However, the study also found that there were intentional and unfair efforts by some health workers who were employed in both the FPFPs and the public sector to displace their competitors (the public sector). These were reported to use some illegal means such as sabotage of equipment of attracting customers to their personal businesses. Such extreme cases of provider induced referrals can also be viewed as shortfalls that the policy levers, particularly dual practice policy, if operationalised, could address.

The existence of other providers did not only influence internal adaptations with in FPFPs but also the heterogeneity of the FPFPs. For example, some managers highlighted the emergence of the demand for specialised services, not provided readily by the existing providers in the public or PFNP sectors, as one of the main reasons they opened FPFPs to offer such services. This was true of the stand-alone laboratory, X-ray and scanning centre as well as the emergence of insurance company clinics post-conflict. In a way, these developments were influenced by the desire to be unique and different from those that already existed but also to have a competitive advantage and meet customers' expectations.

One major finding in Chapter 7 that had not been anticipated was the positive effect or advantages of the existence of other providers/alternatives to FPFPs by facilitating their survival and existence in the market. The alternative providers such as the PNFP and public sector facilities and other FPFPs in the area also presented opportunities for potential collaboration which, some cases, enabled the FPFPs to navigate some costs. One collaboration reported to exist between FPFPs and other FPFPs and between FPFPs and public facilities in the area was in relation to sharing of staff. Ideally, this would be perceived as an illegal dual practice for individual health workers. However, at organizational level, this was perceived as a positive thing, which enabled FPFP facilities to cope with high staff costs by sharing the payment of the salary that would ideally have been shouldered by only one FPFP facility. Furthermore, Chapter 7 provides details of several other relational linkages between FPFPs and other organisations, including other FPFPs, the PNFP and the public sector. The linkages were also illustrated by the dense networks. This issue is further explored under organisational factors.

Organisational factors, which are located at the centre of the conceptual framework (IC**)**, were assumed to play an important role in influencing the contribution of the FPFPs. Among all the factors that had been listed in the initial conceptual framework, age and size of business, skills mix, formal and informal networks, adaptation within the FPFP and, to some small extent, the package of services emerged as important characteristics which had a significant and interconnected role in the contribution of FPFPs towards an pro-poor and equitable health system in post conflict Northern Uganda. However, the initial source of funding and objective function of an organisation did not emerge as very influential except for being characteristics that defined the uniqueness and heterogeneity of the FPFPs.

Initially, the researcher expected the existence of one form of relationship which is more common in the literature – the relationship between FPFPs and the public sector – and that this enabled the FPFP's contribution towards a pro-poor health system. However, the study findings indicated additional relationships such as linkages with other FPFPs, the PNFP/mission sector and the regulators at national and district levels as well as non-health organisations such as supermarkets. The nature of these relationships was also found to be both formal and informal, with some evolving mainly from informal relationships between health workers to formal relationships, while others largely remained informal. Without formal agreements, informal relationships could not be easily reported by respondents, except with further probing. Analysis showed that the benefits of such relationships/networks did not only influence the contribution of FPFPs towards a pro-poor health system but also enabled close interaction of the factors identified in the policy lever factors column (EC2), for example regulation, referrals and policies on dual practice.

The life-history interviews revealed that good and trusting relationships between the customers and the FPFPs built over time enabled the contribution of FPFPs to the pro-poor agenda. For instance, customers were able to access services without necessarily having all the cash at hand. In Chapter 8, loan books, which were established based on a verbal agreement between the provider and the customer, ably elaborated trust between the two parties. This is because customers were given a chance to pay fees charged on a service utilised in a phased manner based on an agreed-upon period, with each payment recorded in the loan book. However, in some cases, particularly where bargaining for price reduction was reported to have taken place, dishonesty of the providers reflected breach of the trust their patients had in them. One of the providers reported having concealed some critical information about the magnitude of the illness which required an operation, thereby creating the false impression that they had reduced the price yet, in actual fact, they were still able to make a profit. This is an example of the negative effects of information asymmetry, which is a crucial concept of NIE.

Among the **policy levers/external controls** indicated in EC 2**,** regulation of the FPFPs was assumed to be an important factor that influenced the contribution of the FPFPs. Initially, registration of the FPFPs (as an aspect of regulation) had been assumed to only influence entry of the FPFPs into the market and merely as an expected compliance criterion to be fulfilled annually. Indeed, the study found that registration seemed to have been enforced, resulting in the acquisition of the necessary documents to operate a business.

However, beyond registration, the enforcement of quality and regulation in relation to area of location seemed to have challenges. The district health office and the

representatives of some professional bodies could play a role as unofficial regulators in the absence of strong state enforcement/capacity during conflict and these need to be incorporated within the policy levers under EC2. Notably, these also had numerous challenges, including role conflict, which affected vigilant policing, as well as financial constraints. The findings in this study, therefore, mimic the situation on the regulation of private health sectors in other FCAs settings such as Somaliland and Afghanistan, where, although regulation is perceived as important, it is either non-existent or limited in enforcement despite the existence of regulatory frameworks (Caitlin et al., 2009, Cross et al., 2016). Nonetheless, some innovations to strengthen regulation during periods of fragility have also been implemented and these have varied in terms of how both formal and informal institutions have been used to implement them. In Somalia, for example, informal institutions, such as clan courts and other networks of trust, have been used as institutions to enforce regulation in the absence of the state (World Bank, 2005). However, in Afghanistan, as a formal institution, the Ministry of Public Health (MOPH) launched a stewardship initiative in 2008 to strengthen oversight and the regulation of the for-profit private organisations (Cross et al., 2016).

Many other scholars are in favour of the use of formal institutions for regulatory purposes and have, therefore, emphasised the need for the state/country governments to take leadership in regulating the for-profit sector in other parts of the world and also indicated the inherent advantages of the approach (Doherty, 2015, Patouillard et al., 2007, McPake and Hanson, 2016). Doherty (2015) points out that government stewardship in regulatory efforts would strengthen the mitigation of disadvantages brought about by the for-profit sector such as distortions in the quality

and price of health services in East and Southern Africa. McPake and Hanson (2016) also argued that state leadership in the regulation of quality in the for-profit sector would enhance the advancement of UHC goals.

Referral policy had been indicated under EC 2 on the right column of the conceptual framework as one of the significant factors for the contribution of FPFPs. Referral policy was never mentioned by the participants. Although those interviewed showed that referrals happened, they seemed to occur “naturally” guided by the networks and relationships between health workers (with in the FPFP facilities and those in other facilities. The practice of referrals was also earlier highlighted as a component of the networks for the FPFPs (part of question 3). Furthermore, referral relationships between FPFPS and other non-FPFP facilities was characterized with unresolved challenges, mainly caused by mistrust and grudges between health workers in private and public facilities. The mistrust was attributed to the perception that health workers in FPFP facilities earned more than their colleagues who worked exclusively in the public facilities and, therefore, never had a chance to engage in dual practice. The study found that some initiatives, such as a district-led dialogue meeting to which FPFP managers and directors of public and PNFP facilities were invited, were helpful. This one-off meeting was aimed at enhancing engagement of providers to ensure improved referrals among health service providers in Gulu municipality. The frequency of occurrence of such dialogues needs to be increased to strengthen the referral-related linkages between FPFPs and other actors within the health care market.

There was a direct causal link between the EC2 factors (policy levers) such as recruitment, remuneration and the management of health workforce policies and the IC factors, particularly adaptation of FPFPs, which led to the perceived contribution of FPFPs. Inadvertent challenges within some of these policy levers enabled the FPFPs to get established hence answering questions 1 and 2, respectively. In chapter 8, it has been reported that the shift-working policy is a challenge because it enables health workers to have extra free time when they are off-duty. Many of the health workers took advantage of to work elsewhere and others to open their own health-related businesses. To some extent, therefore, this policy is central to the influence of the FPFP network linkages which result from sharing human resources for health. Therefore, shift-working policy needs to be included in column EC 2 as one of the policies under the management of the health workforce workload. This is because shift working contributes to the survival of the FPFPs and entrenches dual practice as an unintended consequence.

Dual practice, another factor in EC2, had a direct causal relationship with the contribution of the FPFPs. Dual practice, which generally refers to the practice of holding multiple concurrent clinical jobs in both public and private facilities, is documented as a common phenomenon in both high and low middle-income countries (McPake et al., 2014, Russo et al., 2018, Paina, 2014, Hipgrave and Hort, 2014). This definition characterizes dual practice as only having a likelihood of happening between the public and the private. Available literature indicates four main forms of dual practice that could occur within a system. These include: 1) private practice *outside*; ii) private practice *beside*; iii) private practice *within*; and iv) private practice *integrated* within the public facility (Russo et al., 2013, McPake et al., 2016).

The first two forms of dual practice were more commonly reported by study participants, implying that the majority of the participants held their second jobs in environments outside the public facility which were in some way located at a distance close to the public health facility (McPake et al., 2016). This study provides evidence that dual practice also occurs between private for-profit facilities, a phenomenon which is yet to generate much attention.

In the literature, dual practice has been widely associated with discussions about its effects on service delivery and quality and these have further intensified in the context of universal coverage (McPake et al., 2014, Paina, 2014, Russo et al., 2018). The effects of dual practice include increased patient neglect in the public sector, inefficiencies due to the existence of ghost workers, absenteeism, and long waiting lines among others (Paina, 2014). Hence the evidence available generally depicts dual practice as an illegal practice and this is referred to as the service-level perspective (McPake et al., 2016).

However, McPake et al. (2016) also suggest that the service-level analysis needs to be combined and/or balanced with the system-level analysis of dual practice, which enables one to appreciate the possible benefits of dual practice, such as health worker retention and satisfaction. Many of the study participants seemed to subscribe to the system view. They were reluctant to criminalise dual practice or even provide a hint about the existence of a formal policy to mitigate dual practice. In addition to the provision of an opportunity for individual health workers to earn extra income (McPake et al., 1999), managers perceived dual practice as a coping strategy for FPFP, particularly in the light of staffing costs. Hence, dual practice has benefits beyond the individual health workers. It has also been argued that dual practice, if

regulated appropriately, can improve health service access, the range of services offered and doctors' satisfaction (Hipgrave and Hort, 2014). However, this would be partly dependent on how the health workers balance their time between facilities. In dual practice, time allocation by health workers between facilities can be influenced by numerous factors, including the hourly wage in the private sector, the number of dependents, the length of time spent as a physician, work outside the city, and being a specialist with or without technology (McPake et al., 2014). Furthermore, scholars on dual practice have not only decried its pervasive nature but also underscored the need for strengthening the capacity of LMIC governments to identify and develop appropriate regulatory measures for the various forms of dual practice (Hipgrave and Hort, 2014, Paina, 2014, Russo et al., 2013). Within the context of UHC, insurance companies also provide marketing and financing opportunities for regulating dual practice (Hipgrave and Hort, 2014).

Lastly, the policy on public-private partnerships for health (PPPH) was one of the policy levers in the context of EC2 which was expected to influence the contribution of the FPFPs towards an equitable and pro-poor system. Indeed, Chapters 7 and 8 showed that partnerships between the district health office and FPFPs, albeit limited to a few, enabled the FPFPs to contribute to broader coverage goals for immunisation services. The Third Health Sector Strategic Plan for Uganda 2010-2015 had already highlighted the importance of partnerships and the need for engaging the private sector in order to increase geographical access as well as the scope of services (MOH, 2010a). A policy on PPPH was developed with guidelines for operationalisation (MOH, 2001). However, its operationalisation has been faced with challenges, such as mistrust, lack of appreciation for partnerships among key

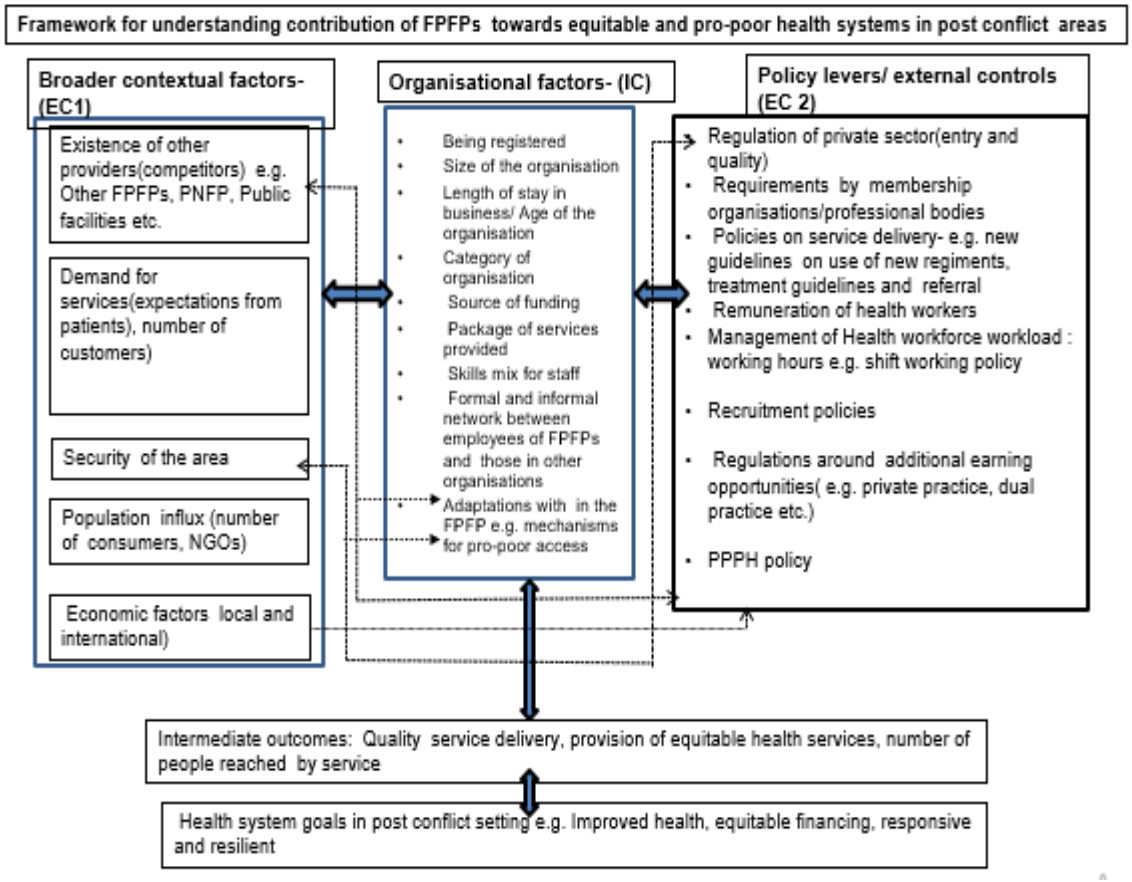
stakeholders in government and weak enforcement (Ssennyonjo et al., 2018). The degree to which partnerships between private providers and government or other organisations can respond to the interests and needs of the poor is dependent on the effective management of relationships between these actors (Bloom et al., 2014). Therefore, the study recommends the operationalisation of the PPPH to include the FPFPs to tap into the available potential.

9.2.1 Empirically derived revised conceptual framework

Section 9.2 was a reflection of the initial conceptual framework (Figure 9) that was introduced earlier in this thesis. To a large extent, the researcher found the initial conceptual framework useful in answering the research questions. However, several unexpected findings and linkages emerged during the analysis. It was thus realised that these would need to be added to the conceptual framework to enhance the understanding of the contribution of FPFPs towards building an equitable and pro-poor health system in post-conflict Northern Uganda. The initial conceptual framework, therefore, had to be adjusted to develop Figure 9. Most of the concepts listed remained the same. However, those that had been missing, such as the PPPH policy and requirements from professional bodies, were added. More arrows indicating direct relationships between some features in the three domains of the conceptual framework which had not been anticipated needed to be indicated, for instance, links between security of the area and features such as regulation, length of stay, adaptation within and adaptations within FPFPs. The relationship between the existence of other providers and features such as adaptations within FPFPs and networks was also illustrated. Lastly, arrows were also drawn to indicate interconnections between demand for services (and expectations) and category of

organisation as well as package of services. Figure 36 illustrates the empirically derived conceptual framework.

Figure 36: Empirically derived conceptual framework



9.3 Summary of Main Findings

9.3.1 Heterogenous nature and evolution of FPFPs

Research question 1 focused on understanding the characteristics and evolution of FPFPs. The FPFPs in Gulu municipality depict a heterogeneous nature (Morgan et al., 2016) and they include both general providers and specialised services, and are varied in terms of size, age of existence, source of income, package of services, staffing and operating hours. This variation illustrates the fragmented and

heterogeneous nature of the private sector that is routinely found in other settings (Mackintosh et al., 2016, International Finance Corporation, Undated, McPake and Hanson, 2016, Morgan et al., 2016, Clarke et al., 2019, Patouillard et al., 2007).

Heterogeneity of FPFPs evolved across the conflict phases, with specialised and somewhat unique categories, including insurance company clinics, stand-alone laboratories, X-ray centres and NGO clinic (hybrid) emerging post-conflict. The findings portray what happens to a market structure during a shift from protracted conflict (humanitarian) to a more peaceful, post-conflict situation (development phase). While FPFP heterogeneity can be found in most places, including the rest of Uganda, what is interesting about those in Gulu is that it kept broadening across the conflict phases and this is an important development in developing/strengthening the district health system and what it offers. The broadening was enabled by conflict opportunities such as the return of peace, urbanisation and the influx of NGOs, among other factors.

The FPFPs in this study varied in their stages of evolution, although the majority were unable to follow the typical life cycle stages of an organisation, as noted by Lester et al. in Chapter 5 (Lester et al., 2003), owing to the conflict-affected environment in Northern Uganda. For instance, the growth of the majority of FPFPs was stunted and they were stuck in a survival stage for a long time instead of blossoming, while some died shortly after they were established, and yet others contemplated closure at an early stage. This scenario mirrors the possibility of an organisation to fail to progress past an early stage or to stagnate at one stage (Lester et al., 2003). Those that remained open for business, however, indicated resilience by showing investments in various areas, including HR and equipment.

9.3.2 Resilience of FPFPs during conflict and post-conflict

The study found that, within their evolution, FPFPs were typified by resilience (Sweeney, 2009) and their resilience, over time, potentially contributed to the broader resilience of health systems in post-conflict settings. FPFPs exercised resilience, considering both the conflict and the numerous challenges experienced post-conflict. Some of the responses related to cost-cutting had serious implications for quality and could potentially affect immediate health outcomes, such as quality service delivery and, therefore, gave rise to the need for increased regulation of these providers.

Chapter 7 showed that FPFPs' relational networks with other organisations (both health and non-health-related) strengthened the survival of FPFPs and enabled their resilience to operate in the dynamic market. The network is illustrated by the many relational links which indicate the exchange of resources between organisations. The networks provided lots of benefits for FPFPs, including HR support, drugs, and equipment, as well as partnerships for service delivery. The exchange of resources enabled by networks reflects an interdependence of actors within the market that emerged post-conflict and an emphasis on the fluidity of boundaries across the public and the private sectors (Sweeney, 2009). In response to this interdependence, Morgan and colleagues (2016) recommend that any state intervention in the private sector needs to not only include individual providers but also focus on other players in the system(Morgan et al., 2016). Furthermore, Chapter 7 indicated the central roles played by FPFPs in the networks, for instance in the referral networks and in health maintenance. These are potential areas which could be explored further when planning the engagement of the formal private for-profit sector. Such networks also need to be nurtured to build the resilience and responsiveness of the health system.

In the early post-conflict phase, some FPFPs, particularly the old ones, reported that they started to provide free services because of partnerships established between them, the district health office in Gulu and some NGOs in the area. This reflects a pattern of the market that seems to emerge in situations of transition from conflict to post-conflict with the potential to contribute to the resilience of the health system in the longer term.

9.3.3. Contribution of FPFPs to building an equitable and pro-poor health system post-conflict.

The fundamental objective of this thesis and research question 3 were focused on understanding the contribution of FPFPs to building an equitable and pro-poor health system. Chapter 8 showed that FPFPs would like to maintain a good image among the public by ensuring that they enable access for the poor, implying that they can contribute to a social mission. However, they continuously faced a dilemma of balancing optimization of their incomes with the altruism objectives. For example, FPFPs implemented various mechanisms to enable the poor to access health services but these were unsystematic and reliant on the presence and judgement of the manager. Some FPFP managers noted that they were keen not to publicize favours such as fee reductions. Key services provided by the FPFPs for use by the poor included mainly Immunisation and other preventive services. The provision of immunization (using supplies from the district administration) made business sense because it created an opportunity to market the range of services offered by the FPFPs to prospective clients.

The FPFPs innovated to contribute to the pro-poor health system. Some of the parameters used by managers to identify the poor have a specific reference to conflict

settings, for example, inability to pay bills, which are also indicated in the Hausmann-Muela framework of vulnerability as part of the long-term effects of conflict, which arise from the destruction of livelihoods of populations (Hausmann-Muela et al., 2003). Other scholars have termed this situation as the 'security-development nexus' or the 'poverty-conflict nexus'. This implies that there is a bi-directional relationship between poverty and conflict, whereby poverty and conflict can reinforce or potentially lead to each other (Goodhand, 2001, Draman, 2003). Even in such settings, however, the degree of poverty may not be the same across all populations. For instance, this may depend on the varying experiences of conflict based on gender or age and among those who participated in the study.

The FPFPs also came up with some innovations and practices around ensuring that payments were manageable for clients. These included loans, fractions/partial doses, and payment in instalments. Some of these mechanisms are not necessarily unique to post-conflict settings but similar to those in some studies conducted among informal providers in relatively stable contexts, such as India and Bangladesh (Bloom et al., 2011). These findings contribute to the evidence that the private sector can also be used as an engine of development and thus to enable the poor to access health services (DFID, 2011). Others have argued that the private for-profit sector can, in fact, have both a profit as well as a social mission (International Finance Corporation, Undated), although the latter is most closely associated with the mission/faith-based sector. Notwithstanding, the general impression within the literature about the private for-profit sector is that it exploits the population by making huge profit. Some scholars have argued that the private sector can deter the achievement of UHC goals(McPake and Hanson, 2016).This is partly due to its

perceived lack of quality and its dependence on OOP expenditure, which results in an increase in catastrophic health expenditures among the poor or discriminates against them (Marriott, 2009, Rachlis, 2007, Morgan et al., 2016). In 2005, the World Bank Group found that OOP expenditures by individuals who sought services from the private sector contributed half of the 60 per cent of the $16.7 million total health expenditure in sub-Saharan Africa. A report about doing business in sub-Saharan Africa indicates the negative effects of what is referred to as 'the pursuit of excess profits' by the for-profit sector. These include unethical business practices such as under- or over-servicing, collusion, false billing, price gouging, and unlicensed practice (International Finance Corporation, Undated). The report, however, also recognises the possible existence of some private for-profit sector that could be responsible and whose efforts may be overshadowed by the misconduct of their counterparts, hence reinforcing the deep-seated suspicion of the private sector.

Notwithstanding, the researcher's overall impression was that, as health businesses, the FPFPs were not necessarily making profits. Where it made business sense to do so, they innovated to contribute to pro-poor health access. However, the FPFPs struggled for survival amidst numerous challenges related to conflict and high operational costs, among other post-conflict challenges and, as noted earlier, many stagnated at certain stages or died shortly after being established.

Chapter 6 showed that FPFPs are struggling with high costs and an effective insurance scheme would assist in coping with some costs. However, this would reflect type 5 of the stratified private sector, which can reinforce inequality, given that some may not afford and escalate operational costs (Mackintosh et al. 2016). Despite the skepticism, the evidence here highlights the presence of a growing insurance

sector in the conflict-affected areas and presents scenarios to stimulate debates in the ongoing global-level discussions about how private sector entities can be engaged for the public good as well as towards the advancement of UHC (McPake and Hanson, 2016, Gautham et al., 2019). At national level, in Uganda, there is an ongoing debate about the modalities of implementing the National Insurance Scheme (MOH, 2019). Possibilities can also be explored whereby the government would pay a premium for those who may not be able to afford insurance(Akal and Harvey, 2001, Kotoh and Van der Geest, 2016). This would enable the mitigation of cost escalation and reduce the effect of price on demand for services (McPake et al. 2013). Lessons can also be learnt from countries such as Rwanda where community health insurance has contributed to increased medical care utilization and decreased OOP expenses (Chemouni, 2018). In the context of UHC, however, insurance has been criticized for contributing to health inequities by further disadvantaging the poorest and the unhealthiest as they may not have the money to pay the premium (Kotoh and Van der Geest, 2016, Oxfam., 2013, Wang et al., 2017). In order to address the challenges related to community insurance and government-funded insurance as well as meet the multiple objectives of efficiency and equity, multiple funding sources for insurance are recommended (Akal and Harvey, 2001).

9.4 Limitations of the Study

The findings of this study need to be considered within the context of several limitations. The study limitations included lack of focus on the quality of services, supply-side bias, social acceptability/desirability bias, limited generalizability of findings, limitations of the survey and limited focus on regulation. These are explained below.

No focus on the quality of services

Although the researcher acknowledges that the quality of services provided by the private sector is at the centre of debate, the study did not investigate quality issues although some insights about quality emerged. Nevertheless, the focus was to understand the evolution of FPFPs and the extent to which they contribute to the pro-poor agenda.

Supply-side bias

The study was biased towards the 'supply side' and did not seek out clients' views on whether the FPFPs were contributing to the provision of equitable and pro-poor services. However, using the organisational survey, the study was able to generate insights about which categories of people sought services from the private sector and which categories were targeted for the provision of free services or price reductions. Using life histories, however, the study presents an in-depth investigation of the private sector while discussing the major events in the existence of the business across conflict phases. This interview method was a rather new way of gathering information about the sector, hence the study made a methodological contribution.

Social acceptability bias

The study also experienced a potential social acceptability bias because it relied on provider self-reports of their characteristics and behaviour, particularly in relation to actions for enabling access to the poor (Fisher and Katz, 2000). Social acceptability bias occurs when the persons interviewed either over-report good behaviour or under-report bad behaviour (Lavrakas, 2008). Hence, in this study, the researcher cannot rule out the possibility that providers answered questions in a manner that

made them to be viewed positively as a sector. For instance, the survey questionnaire included questions about a pre-generated list of disadvantaged groups in Gulu to whom FPFP facilities were providing services. The majority of the 45 FPFPs surveyed responded with a 'yes' to almost all the categories, with a few even reporting that they were 'providing services to all people in Gulu'. The questionnaire also included questions about whether the FPFPs were providing fee exemptions and reductions to the same list of people. To this question, the majority responded 'yes'. However, the questions about the types of services that were fee-exempt or to which reductions applied indicated some insights that the providers' responses needed to be triangulated.

During the life-history interviews, however, the researcher further triangulated the results in the survey and asked for explanations, scenarios, and justifications in relation to fee exemptions and fee reductions. The explanations provided in Chapter 8 indicate that the providers experienced a dilemma involving the need for profit maximization and their social mission. Furthermore, although the providers had been reluctant to answer a question about how much profit they were making[39], the researcher used proxies, such as the number of customers over time, to assess the amount of profit being made. Nonetheless, the probes carried out during the life-history interviews (see Chapter 8) also, to an extent, reflected instances where the providers could make a profit, for instance, areas in which bargaining for price reduction could be done. The researcher believed that the rapport created between her and the managers during the life-history interviews made the latter adequately

[39] A question about profit was removed from the questionnaire after the pre-test

comfortable to talk about both the negatives and the positives without getting too concerned about whether the responses might affect their social desirability.

Limited generalizability of findings but the provision of insights

The relatively small number of organisations that were involved in the survey – which was anticipated – may limit the precision and the generalizability of the survey results. The number that took part in the survey were influenced by the list provided by the district officials and by the willingness of some FPFPs to participate in the survey. Additionally, the small number of life histories conducted may also not enable generalizability. Nevertheless, the information gathered through these methods provides a general picture about the formal for-profit sector as well as insights about the survival of businesses in post-conflict settings, including Northern Uganda.

The study was conducted in Gulu, one of the eight, but also most urban, districts in the Acholi sub-region. Gulu district has also, to date, been a hub of benevolent and/or humanitarian activity for many international and national NGOs, which may, in very many ways, influence the establishment of several FPFPs and the demand for services provided by FPFPs compared to the other districts in the same region. Therefore, generalization of the findings to the other districts in the region may be limited.

Limited deliberate focus on regulation

Whereas the researcher acknowledges the centrality of regulation to the debate about the private sector, this study did not have an in-depth focus on regulation. The researcher also realised that a detailed focus on regulation could not align well with the chronology of the research questions. Nevertheless, the study findings (see Chapters 5 and 7) highlighted the role of regulation in the context of the market within

which the FPFPs operate, the network links in relation to regulation, how regulation has changed across phases as well as the challenges and coping strategies used by both the regulators and the providers. The researcher plans to solicit funding to undertake work around stakeholder engagement to improve regulation in the region and dig deeper into how the self-regulation initiative that was mentioned by the study participants can be operationalised.

Limitations of the survey

The researcher acknowledges that the survey was limited in explaining some of the descriptive issues. For instance, the survey could not sufficiently explain the increase in the number of FPFPs over time. Hence, the researcher triangulated this finding with information from key informant interviews. In this case, recollections of regulators about the names, numbers and locations of the FPFPs that were open during and after the conflict provided a good supplement to the survey findings in supporting the claim that the number of FPFPs had increased over time.

9.7 Conclusions and Recommendations

The central argument in this study was that in order to understand the extent to which the FPFPs contribute to building an equitable/pro-poor health system in the post-conflict period, we need to understand the factors that influence/have influenced this 'contribution' over time. Above all, the study attempted to present the voices and experiences of the FPFPs in Gulu using the life-history interview method, which enabled a retrospective interrogation. The researcher supplemented this information with data from key informant interviews, observation, and document analysis.

The researcher concludes by noting that despite the challenges faced by the private sector and the doubt regarding the contribution of the sector, the FPFPs play a critical role in service delivery and can, indeed, contribute to UHC. This happens amidst the continuous dilemma they face of balancing their profit maximization against the altruism objectives.

Additionally, the contribution of the FPFPs depends on various factors, including those that are internal and unique to FPFPs, as well as factors within the broader internal and policy environment in which the FPFPS operate. These include the length of stay, the size, and networks of the organisations, as well as the presence and judgement of the manager.

The findings chapters have shown that conflict was a key influencing factor in the establishment, survival, and growth of FPFPs. Conflict also affected the quality of regulation for the FPFPs. Interventions in the private sector in such settings need to consider the aspect of organisation of the market structure for FPFPs, which was shaped by conflict.

The mechanisms employed by the FPFPs to enable the poor to access services from these providers are partly aimed at maintaining or attracting customers or creating a good public image rather than exclusively reducing the financial burden of the poor. Altruism can be embraced for UHC but the coping strategies for profit maximization might raise quality and regulatory challenges. However, to ensure equitable access among service users, the altruistic mechanisms need to be institutionalized and standardized within and across FPFPs. Furthermore, mechanisms to facilitate the operationalisation of the PPPH, e.g. results-based financing (RBF) and sustained technical support and provision of equipment, need to be strengthened. This will

enable the for-profit sector to reduce their financial burden, broaden the scope of free and/or subsidized services, and increase the population served.

Increased regulation of the private sector by the government using incentives for good performance and law enforcement for poor performance is recommended to minimize quality and regulatory challenges. Self-regulation by the private sector (reported as a one-off event) can also be promoted further, although this needs to be undertaken with caution and, if implemented, requires continuous monitoring as many FPFPs may fall through the cracks if left to their own devices.

The dense networks and relational linkages between the FPFPs and other health and non-health organisations in the area have shown that the FPFPs are already embedded in the fabric of the pluralistic health system in Gulu. Therefore, we cannot merely wish them away. Rather, we need to leverage their strengths while also improving the regulation to mitigate the quality issues and catastrophic expenditure.

Despite the expectation by the public and pro-UHC supporters that the sector would contribute broadly to a social mission, the private for-profit providers cannot be pro-poor, given that they are formed with the objective of making profits. Their contribution towards a social mission can be strengthened through support from the district office and partnerships with NGOs. The support can have overarching benefits for the broader UHC agenda as, at the same time, it benefits the FPFPs. Currently, this support is limited to a few FPFPs and, therefore, needs to be continued and expanded across more FPFPs. Lastly, regardless of its contribution, the private for-profit sector in general cannot be left alone in health service provision in such settings. Rather, the state also needs to regain its legitimacy, particularly in settings where the health sector has previously been battered by conflict.

9.6. Areas for Further Research and Development

There are three areas for further research, which, given the constraints within which I worked and the limitations of focus for the study objectives, I could not investigate further and would like to expand on in the future.

First, there is need to undertake work around stakeholder engagement to improve regulation in the region and to conduct a further inquiry into how the self-regulation initiative that was mentioned by the study participants can be operationalised.

Second, the study findings indicated challenges in relation to referrals between FPFPs and non-FPFPs. Furthermore, the findings showed that some discussions on the matter were enabled, although these were one-off. With funding, I hope to ignite stakeholder engagement and discussions about the improvement of referrals between FPFPs and other providers in the region (such as sub-national stakeholder engagement to improve health service delivery).

Third, the study revealed innovations around altruism among FPFPs. Further research needs to be conducted in relation to how this altruism can be operationalised for the advancement of UHC.

REFERENCES

ABDULLA, S., SCHELLENBERG, J., NATHAN, R., MUKASA, O., MARCHANT, T., SMITH, T., TANNER, M. & LENGELER C 2001. Impact on malaria morbidity of a programme supplying insectcide treated nets in children aged under 2 years in Tanzania: A community cross sectional study. . *BMJ,* 322**,** 270-273.

ABU-SAIFAN, S. 2012. Social Entrepreneurship: Definition and Boundaries *Technology Innovation Management Review***,** P.25.

ADB-DFID 2005. Making Market Systems Work Better for the Poor (M4P): an Introduction to the Concept. Discussion paper prepared for the ADB-DFID 'Learning Event'. ADB Headquarters, Manila.

ADDISON, T. & LAAKSO, T. 2000. Conflict in Zimbabwe. *Paper presented at UNU/WIDER Project meeting on 'why some countries avoid conflict while other fail'.* Helsiki 20-21 October.

ADDISON, T., MURSHED, S. & MANSOOB, S. 2001. The Fiscal Dimensions of conflict and reconstruction. . *WIDER discussion Paper, No. 2001/49.* Helsinki: The United Nations University. World Institute for Development Economics Research(UNU- WIDER).

AGER, A., LEMBANI, M., MOHAMMED, A., ASHIR, M., ABDULWAHAB, A., PINHO, D., DELOBELLE, P. & ZAROWSKY, C. 2015. Health Service resilience in Yobe state, Nigeria in the context of the Boko Haram insurgency: A systems dynamics analysis using group model building. *Conflict and Health,* 9.

AKAL, A. & HARVEY, R. 2001. The role of health insurance and community financing in funding immunisation in developing countries. Financing Task Force for the Global Alliance for Vaccines and Immunisation(GAVI).

AKOL, A., MOLAND, K. M., BABIRYE, N. J. & ENGENBRETSEN, M. S. I. 2018. "We are like co-wives": Traditional healers' views on collaborating with the formal Child and Adolescent Mental Health System in Uganda. *BMC Health Services Research,* 18.

ALFONSO, N., BISHAI, D., BUA, J., MUTEBI, A., MAYORA, C. & EKIRAPA- KIRACHO, E. 2015. Cost effectivenes analysis of a voucher scheme comnbined with obstetrical quality improvements. Quasi experiemental results from Uganda. *Health policy and planning,* 30**,** 88-99.

ALLIED HEALTH PROFESSIONALS COUNCIL. 2000. Allied Health Professionals Act Chapter 286. *In:* PROFESSIONALS, A. H. (ed.). Kmapala, Uganda.

ALMA ATA DECLARATION 1978. International Conference for Primary Health Care. Alma Ata, USSR.

ANDREWS, T. 2012. "What is Social Constructionism?". *Grounded Theory Review* 11**,** 1-8.https://pdfs.semanticscholar.org/71a70/07845a07991b02707e04520df06779a84789df07844ab.pdf.

APPLETON, S., EMWANU, T., KAGUGUBE, J. & MUWONGE, J. 1999. Changes in poverty in Uganda, 1992 -1997. Working Paper WPS/99.22,. Centre for the study or African Economics,Oxford University.

ARC 2007. Knowledge, attitudes and practices relating to youth and conflict in Northern Uganda. A report for Uganda Country Programme.

. ARC (American Refugee Committee International).

ASIIMWE, D. & NAKANYIKE, B. 2007. *Decentralisation and Transformation of Governance in Uganda,* Kampala, Fountatin.

ATKINSON, R. 1998. *The Life story Interview, Qualitative Research methods series 44.* , Sage Publications.

AVIS, W. A. 2016. Private Sector engagement in fragile and Conflict affected settings (GSDRC Helpdesk Research Report 1331). . *Helpdesk Researh report.*

. Birmingham,UK: Governance SocialDevelopment Humanitaria and Conflict Applied Knowledge Services.
AVSI. 2011. Comprehensive Health Facility Assessment survey for Acholi Sub-region. Gulu: Association of Volunteers Overseeas.
BANDY, J. 2000. Bordering the Future: Resisting Neoliberalism in the Borderlands. *Critical Sociology,* 26**,** 232-267.
BELLOWS, N. 2012. Vouchers for reproductive health care services in Uganda and Kenya: Approaches supported by financial cooperation. Frankfurt am Main, Germany: KFW Entwicklungbank. Competency centre for health, education and social protection.
BENJARATTANAPORN P., LINDAN CP., MILLS, S., BARCLAY, J., BENNETT, A., MUGRDITCHIAN, D., MANDEL, J. S., PONGSWATANAKULSIRI, P. & WARNNISSORN, T. 1997. Men with sexually transmitted diseases in Bangkok: where do they go for treatment and why? *Aids,* Vol. 11**,** pp.87-95. .
BENNETT, S., LARGOMASINO, G., KNEZOVICH, J. & LUCAS, H. 2014. Accelerating learning for pro-poor health markets. *Globalisation and Health,* 10.
BERGER, P. & LUCKMANN, T. 1991. *The social construction of reality.,* London, Penguin Books.
BERGH, S. 2012. Introduction: Researching the effects of neoliberal reforms on local governance in the Southern Mediterranean. *Mediterranean Politics,* 17**,** 303-321.
BERTONE, M., FALISSE, J., RUSSO, G. & WITTER S. 2018. Context matters (but how and why?) A hypothesis-led literature review of performance based financing in fragile and conflict-affected health systems. *Plus One,* 13.
BERTONE, M., JOWETT, M., DALE, E. & WITTER, S. 2019. Health financing in fragile and conflict-affected settings: What do we know, seven years on? . *Social Science and Medicine,* 232**,** 209-219.
BIRD, K. 2008. Using life history research as part of a mixed methods strategy to explore resilience in conflict and post conflict settings. [Online] Available from: http://www.chronicpoverty.org/uploads/publication_files/bird_mixed_methods.pdf. Viewed March 2013
BIRUNGI, H., MUGISHA, F., NSABAGASANI, X., OKUONZI, S. & JEPPSON, A. 2001. The Policy on Public-Private mix in the Ugandan health sector: catching up with reality. *Health policy and planning,* 16**,** 80-67.
BLOOM, G., KANJILAL, B., LUCAS, H. & PETERS, H. D. (eds.) 2013. *Transforming Health markets in Asia and Africa: Improving quality and access for the poor. ,* London and New York.: Routledge.
BLOOM, G., STANDING, H. & LLOYD, R. 2008. Markets, Information Asymmetry and Health care: Towards New Social Contracts. *Social Science & Medicine,* 66**,** 2076-87.
BLOOM, G., STANDING, H., LUCAS, H., BHUIYA, A., OLADEPO, O. & PETERS H.D. 2011. Making health markets work better for poor people: The case of informal providers. *Health policy and planning,* Vol. 26**,** Pp. i45-i52.
BLOOM, G., WILKINSON, A., STANDING, H. & LUCAS, H. 2014. Engaging with health markets in Low and middle income countries. *IDS working paper 443.* Tottenham, UK: Institute of Development Studies.
BORGATTI, S. & EVERETT, M. 1999. Models of Core/Periphery Structures. *Social Networks,* 21**,** 375-395 https://doi.org/10.1016/S0378-8733(99)00019-2
BRANCH, A. 2007. Gulu town in war … and peace? Displacement, humanitarianism, and post-war crisis. Working Paper No. 36, . Crisis States research Centre, London School of Economics.

BRANCH, A. 2013. Gulu town in war … and peace? Displacement, humanitarianism, and post-war crisis. *Journal of Urban Studies.,* Vol 50.

BROWN, J. & DELOITTE & TOUCHE 1994. Agroindustrial investment and operations. . Washington DC: World Bank.

BROWN, M. 2006. "The failing humanitarian response in Northern Uganda,". *Humanitarian Exchange,* 36.

BRÜCK, T. & BOZZOLI, C. 2008. Fragility in Northern Uganda: Camp Decongestion and Child Health Status. *USAID Workshop on Poverty Reduction in Conflict and Fragile States, April 2.* Washington DC, : German Institute for economic research (DIW) Berlin, Humboldt University and Households in Conflict Network (HiCN)[Accessed February 12th 2014]

BRYMAN, A. 1995. Research Methods and Organizational studies. Contemporary Social research Series (20). *In:* BULMER, M. (ed.) *Contemporary Social research Series (20).* London: Routledge.

BRYMAN, A. 2012. *Social Research methods 4th Ed.,* New York, Oxford University press Inc.

BUCKELY ET AL. 2015. Assessment of the Private Health Sector in Somaliland, Puntland and South Central.: DFID Health education Advice and Resource team (HEART).March 2015. https://assets.publishing.service.gov.uk/media/57a0899bed915d622c0002e3/Assessment-of-the-Private-Health-Sector-in-Somaliland-Puntland-and-South-Central.pdf

CAITLIN, M., C., , AHMED, R. & DAVIS, A. 2009. The private sector and health. A survey of Somaliland private pharmacies. Report 11. https://www.socialscienceinaction.org/resources/private-sector-health-survey-somaliland-private-pharmacies/.

CALL, C. 2011. Beyond the 'failed state'" Toward conceptual alternatives. *European Journal of International Relations,* 17**,** 303-326.

CHAMBERS, R. 1980. Rural poverty unperceived: Problems and Remedies. Brighton BNI,9 RE UK: Institute of Development Studies University of Sussex.

CHARMAZ, K. 2006. *Constructing Grounded Theory: A practical guide through qualitative analysis,* Thousand Oaks CA, Sage.

CHEMOUNI, B. 2018. The political path to universal health coverage: Power, ideas and community-based health insurance in Rwanda. *World Development,* 106**,** 87-98.

CLARKE, D., DOERR, S., HUNTER, M., SCHMETS, G., SOUCAT, A. & PAVIZA, A. 2019. The Private sector and Universal Health Coverage. *Bulletin of the world Health Organisation,,* 97**,** 434-435.

CLARKE, S. 2005. The Neoliberal Theory of Society. *In:* SAAD-FILHO, A. & JOHNSTON, D. (eds.) *Neoliberalism.* Pluto Press.

COASE, R. 1937. The nature of firms and their costs. *Economic Insights,* 8.

COLE, L. & KNOWLES, L. G. (eds.) 2001. *Lives in Context: The Art of Life History Research* Oxford, United Kingdom: Altamira Press.

COLLIER, P., ELLIOT, V., HAVARD, H., HOEFFLER, A., REYNAL-QUEROL, A. & N., S. 2003. Breaking the Conflict Trap: Civil war and Development. A World Bank policy research report. Washington, DC.: World Bank and Oxford University Press.

CONTEH, L. & HANSON, K. 2003. Methods for studying private sector supply of public health products in developing countries: a conceptual framework and review. *Journal of social science and Medicine,* Vol. 57**,** pp. 1147-1161.

CRESWELL, J. W. 1998. *Qualitative inquiry and research design: Choosing among the five traditions,* London, New Delhi., Sage Publication, Thousand Oaks

CRESWELL, J. W. 2007. *Qualitative inquiry and research design: Choosing among five approaches (2nd ed.,* Thousand Oaks CA, Sage.

CRESWELL, J. W. 2012. *Educational research: Planning, conducting, and evaluating quantitative and qualitative research (4th ed.),* Boston, MA, Pearson.

CRESWELL, J. W. & PLANO, C. 2011. *Designing and conducting Mixed Methods Research 2nd edn,* Thusand Oaks CA., Sage.

CROSS, H., SAYEDI, O., IRANI, L., ARCHER, L., SEARS, K. & SHARMA, S. 2016. Government stewardship of the for-profit private health sector in Afghanistan. *Health policy and planning,* 32**,** 338-348.

CROTTY, M. 1998. *The Foundations of Social Research: Meaning and Perspective in the Research Process,* Los Angeles, London, New Delhi and Singapore, Sage Publications

DAVIES, C. A. 1999. *Reflexive ethnography. A guide to researching selves and others,* London, Routledge.

DE VRIES, T. & SPECKER, L. 2009. Early Economic recovery in Fragile states: priority areas and operations challenges. http://enterprise-development.org/download.ashx?id=1727. Clingendael Institute.

DECOSTA, A. & DIWAN, V. 2007. Where is the public health sector? Public and private sector health care provision in Madya Pradesh, India. *Journal of Health policy,* Vol 2-3**,** pp. 269-76.

DELLOITTE 2019. Uganda Budget highlights 2019/20. Unravelling the puzzle. https://www2.deloitte.com/content/dam/Deloitte/ug/Documents/tax/Budget_highlights_UG_2019.pdf

DEQUECH, D. 2005. The New institutional economics and the theory of behaviour under uncertainty. *Journal of Economic behavious and organisation* 59**,** 109-131.

DFID 2011. The engine of development: the private sector and prosperity for poor people. 1 Palace Street London SW 1E 5HE: Department for International Development(DFID).

DFID. 2013. *Harnesing non-state actors for better health for the poor* [Online]. Available: https://www.gov.uk/guidance/harnessing-non-state-actors-for-better-health-for-the-poor-hanshep [Accessed].

DOHERTY, J. 2011. Expansion of the private health sector in East and Southern Africa, EQUINET Discussion Paper 87. EQUINET: Harare. http://www.equinetafrica.org/bibl/docs/EQ%20Diss%2087%20Private%20HS.pdf. *EQUINET Discussion Paper 87.*

[Online]. Available:

DOHERTY, J. 2013. We cannot leave the for-profit health sector unregulated in Africa: An editorial for the EQUINET newsletter 150. August 1st 2013. http://equinetafrica.org/newsletter/index.php?issue=150#1. *EQUINET newsletter 150* [Online]. Available: .http://equinetafrica.org/newsletter/index.php?issue=150#1.

DOHERTY, J. 2015. Regulating the for-profit private health sector. Lessons from Eastern and Southern Africa. . *Health Policy and Planning,* 30**,** i93–i102.

DOUMA, S. & SCHREUDERS, H. 2002. *Economic approaches to organisations,* London, Pearson education limited.

DOWNIE, R. 2012. The State of Public Health in South Sudan. critical condition. A report of the Centre for strategic and international Studies. global health policy center. https://csis-prod.s3.amazonaws.com/s3fs-public/legacy_files/files/publication/121114_Downie_HealthSudan_Web.pdf.

DRAMAN, R. 2003. Poverty and Conflict in Africa: Explaining a Complex Relationship. . *Experts Group Meeting on Africa-Canada Parliamentary Strengthening Program.* Addis Ababa, May 19-23, 2003.

EGGERTSSON, T. 2013. Quick guide to New Institutional Economics. *Journal of comparative economics,* 41**,** 1-5.

EKIRAPA- KIRACHO, E., WAISWA, P., RAHMAN, M., MAKUMBI, F., KIWANUKA, N., OKUI, O., RUTEBEMBERWA, E., BUA, J., MUTEBI, A., NALWADDA, G., SERWADDA, D., PARIYO, G. & H.D., P. 2011. Increasing access to institutional deliveries using demand and supply side incentives: early results from a quasi-experimental study. *BMC International Health Human rights,* 11.

ELLIOT, D., GIBSON, A. & HITCHINS, R. 2008. Making markets work for the poor: rationale and practice. *Enterprise Development and Microfinance,* Vol. 19**,** 101–19.

ELLIS F 1990. *Agricultural Policies in Developing Countries. Cambridge University Press.*, Cambridge University Pres.

ENSOR, T. & WEINZEIRL, S. 2006. A review of regulation in the health sector in low and middle income countries,working paper. Oxford Policy Management.

FISHER, R. & KATZ, J. 2000. Social Desirability bias and the vailidity of self reported Values. *Pyschology and Marketing,* 17.

FUSTUKIAN, S., VIDAL, N. & SSALI, S. 2017. Analysing health care seeking patterns in households from life histories in Gulu District, Northern Uganda(1962-2013)- A research report. ReBUILD Consortium.

GAUTHAM, M., BALASUBRAMANUIM, P., BLOOM, G., LAKEW, D. & FORSBERG, C. B. 2019. Private Sector Capacity for Public Good: How the private sector can contribute to UHC. *https://www.healthsystemsglobal.org/blog/344/Private-Sector-Capacity-for-Public-Good-How-the-private-sector-can-contribute-to-UHC.html* [Online]. [Accessed 21-May-2019.

GAUTHAM, M., SHYAMPRASAD, K. M., SINGH, R., ZACHARIAH, A., SING, R. & BLOOM, G. 2014. Informal rural healthcare providers in North and South India. *Health policy and planning***,** i20-i29.

GEORGE, A. L. & BENNETT, A. 2005. *Case Studies and Theory Development in the Social Science,* Cambridge, MIT Press.

GERRING J. 2004. What is a case study and what is it good for? *The American Political Science Review,* 98**,** p. 341–354.Inštitut za slovenski jezik Frana Ramovša ZRC SAZU, laboratorij.

GILSON, L. 2003. Trust and the Development of Health as a social institute. *Social Science and Medicine,* 56**,** 1453-68.

GILSON L, BARASA E, NXUMALO N & 2017., E. A. 2017. Everyday resilience in district health systems: emerging insights from the front lines in Kenya and South Africa. *BMJ Global Health,* 2.

GOODHAND, J. 2001. Violent conflict, poverty, and chronic poverty. CPRC Working Paper 6. London: Chronic Poverty Research Centre, ODI. http://www.chronicpoverty.org/uploads/publication_files/WP06_Goodhand.pdf.

GOVERNMENT OF UGANDA 2018. Conditional Grant Utilisation agreement for the fiancial year 2018-2019 between ministry of health and local governments. Kampala, Uganda: Government of Uganda.

GOVERNMENT OF UGANDA. 2010. Public Service Standing Orders 2010. *In:* SERVICE, M. O. P. (ed.). Kampala.

GRAVES, C. M., HAAKENSTAD, A. & DIELEMAN, J. 2015. Tracking development assistance for health to Fragile states 2005-2011. *Global health* 11.

GREGORY, C. 2000. The "Survival of the Fittest" and the Origins of Social Darwinism. *Journal of the History of Ideas,* 61**,** 223-240.

GUHA-SAPIR, D. & D'AOUST, O. 2010. Demographic and health consequencies of civil conflict. *World Development Report 2011. Background paper.* Brussels, Belgium: Centre for Research on the Epidemiology of Disasters,Universite Catholic de louvain, School of Public Health

GUISTI, D., CRIEL, B. & X., B. 1997. View point: Public s private health care delivery: Beyond slogan. *Health policy and planning,* 12**,** 193-8.

HAMMERSLEY, M. 1992. *What's Wrong with Ethnography? ,* London., Routledge.

HARDY, C., PHILLIPS, N. & CLEGG, S. 2001. 'Reflexivity in organization and management theory: A study of the production of the research subject'. *Human Relations,* 54(5**,** 531–560.

HARRISON, B., SMITH, C. & DAVIES, B. 1992. The Price Mechanism and Market Failure. In: . *Introductory Economics.* London: Palgrave.

HARTLEY, J. 2004. Case study Research. *In:* CASSELL, C. & SYMON, G. E. (eds.) *Essential Guide to Qualitative Methods in Organizational Research.* London.

HARVEY, D. 2005. *A Brief History of Neoliberalism,* Oxford, Oxford University Press.

HIPGRAVE, D. & HORT, K. 2014. Dual practice by doctors working in South and East Asia: a review of its origins, scope and impact, and the options for regulation *Health policy and planning,* 29**,** 703-16.

IDMC 2008. Uganda: Focus shifts to securing durable solutions for IDPs. A profile of the internal displacement situation. Internally Displaced Monitoring Centre, Norwegian Refugee Council. .

IHEA 2009. The role of the private sector in health . Pre-congress symposium. Symposium report. The world congress of the international health economics association (IHEA). Beijing 11 July 2009

INSTITUTE FOR HEALTH SECTOR DEVELOPMENT 2004. Private sector participation in health. London, United Kingdom.

INTERNATIONAL FINANCE CORPORATION Undated. The Business of Health in Africa. Partnering with the Private Sector to Improve People's Live. International Finance Corporation(IFC), The Wolrd Bank group.

IOM 2006. HIV and AIDS Mapping: HIV and AIDS Service Provision to IDP Communities in Northern Uganda. Kampala: International Organisation for Migration (IOM).

KAMAL- YANI, M. 2015. Private for Profit Health providers. A panel discussion at the International Conference on Public Policy, Milan 1-3 July 2015, http://www.globalhealthcheck.org/?p=1782. *International Conference on Public Policy.* Milan

KAWULICH. 2012. Collecting data through observation,

. *In:* C. WAGNER, B. K., M. GARNER (ed.) *Doing Social Research: A global context.*

. McGraw Hill.

KELLY, K. & VAN DER RIET, M. 2001. Participatory research in community settings: Processes,methods and challenges. *In:* SEEDAT, M. & LAZARUS, S. (eds.) *Community psychology: Theory, method and practice. South African and other perspectives.* Cape Town: Oxford University Press.

KENTIKELENIS, A. 2017. "Structural adjustment and health: A conceptual framework and evidence on pathways" *Social Science and Medicine,* xxx**,** 1-10.

KIKUMBIH, N., HANSON, K., MILLS, A., MPONDA, H. & SCHELLENBERG, J. 2005. The economics of social marketing: the case of Mosquito nets in Tanzania. *Social Science and Medicine,* 60**,** 369-381.

KINDI, F. I. 2010. Challenges and Opportunities for Women's Land Rights in the Post-Conflict Northern Uganda. . *A Micro Level Analysis of Violent Conflict (MICROCON) MICROCON Research Working Paper no. 26.* Brighton: Institute of Development Studies, University of Sussex.

KIWANUKA, M. 2013. National Welfare or Local Welfare?" The fiscal Decentralisation Paradox in Uganda. *African Asian Local Government Studies***,** 92-106.

KONDE- LULE, GITTA J., N.S., LINDFORS, A., OKUONZI, S., ONAMA, O. V. & AND FORSBERG, C. B. 2010. Private and public health care in rural areas of Uganda. *Journal of BioMed Central (BMC) International Health and Human rights. Available from; http://www.biomedcentral.com/1472-698X/10/29*.

KONDE-LULE, J., OKUONZI, S., MATSIKO, C., MUKANGA, D., ONAMA, O. V., GITTA, N. S., BERMAN, P., FORSBERG, C. B. & LIU, Y. 2006. The potential of the private sector to Improve Health outcomes in Uganda. Karolinska Institute, Stockholm, Harvard School of Public Health, Boston, USA and Makerere University Institute of Public Health, Kampala, Uganda.

KOTOH, A. M. & VAN DER GEEST, S. 2016. Why are the poor less covered in Ghana's national health insurance? A critical analysis of policy and practice. *International Journal for Equity in Health,* 15.

KYOMUHENDO, G. B. 2003. Low use of rural maternity services in Uganda: impact of women's status, traditional beliefs and limited resources

Reporductive Health Matters, 11**,** 16-26.

LAGOMARSINO, G. 2013. The Private Sector in Health Symposium. Harnessing Informal Providers for Health Systems Improvement: lessons from India. Growing knowledge about the role of informal providers with in health systems. 6 July 2013. Sydney Australia,: Centre for Health Market Innovations and Future Health Systems Consortium. Available from: http:// www.pshealth.org/site/privatesectorhealth/2013-symposium/webnar-series/130205-harnessing-informal-providers. Accessed March 2014.

LAVRAKAS, P. (ed.) 2008. *Encyclopedia of survey research methods,* Thousand Oaks, CA: Sage Publications, Inc.

LEEDY, P. D. & ORMROD, J. E. 2005. *Practical Research: Plannng and design,* N.J., Prentice Hall.

LEININGER, M. (ed.) 1985. *Qualitative Research Methods in Nursing,* New York: Grune & Straton Publishers.

LESTER, L., PARNELL, A. & CARRAHER, S. 2003. Organisational Life cycle: A five stage Empirical Scale. *International Journal of Organisation Analysis,* 11.

MACKINTOSH, M., CHANNON, A., KARAN, A., SELVARAJ, S., ZHAO, H. & CAVAGNERO, E. 2016. What is the private sector? Understanding private provision in the health sytems of low- income and middle-income countries. *UHC: Markets , profit and the public good1.* The Lancent.

MACRAE, J., ZWI, A. & GILSON, L. 1996. A triple burden for health sector reform: Post coflcit rehabilitation in Uganda. *Social Science and Medicine,* 42**,** 1095-108.

MAKHOKA, A. 2001. Structural Adjustment participatory review inititiative(SAPRI): Uganda Country Report. A synthesis of four studies. Kampala, Uganda.

MANGWI, R. A., RUTEBEMBERWA, E. & MARTINUEU, T. 2019. Posting Policies do not change because there is peace or war: The staff deployment challenges for two large health employers during and After Conflict in Northern Uganda. *Human Resources for Health* 17.

MAREK, T., DIALLO, I., NDIAYE, B. & RAKOTOSALAMA, J. 1999. Successful contracting of prevention services: fighting manutrition in senegal and Madagascar. *Health policy and planning,* 14**,** 382-389.

MAREK, T., O'FARREL, C., YAMAMOTO, C. & ZABLE, I. 2005. Trends and Opportunities in Public-Private Partnerships to Improve Health service delivery in Africa. *African region Human Development working paper.* Washington DC: The World Bank.

MARRIOT, A. & NDOUR, M. 2013. Making the private health care sector deliver for the poorest: common sense or blind optimism

MARRIOTT, A. 2009. Blind Optimism: Challenging the myths about private health care in poor countries, Briefing Paper 125, Oxfam International. https://www.oxfam.org/sites/www.oxfam.org/files/bp125-blind-optimism-0902.pdf

MARTINEZ, E. & GARCIA, A. 1997. What is Neoliberalism? A brief definition for Activists. Corpwatch: National Network for Immigrant and Refugee Rights.

MAVROUDEAS AND PAPADATOS. 2005. Neo-Liberalism and the Washington Concensus.

MAXCY, S. J. 2003. Pragmatic threads in mixed methods research in social sciences: the search for multiple modes of inquiry and the end od the philosophy of formalisation. *In:* TASHAKKORI, A., AND TEDDLIE, C., (ed.) *Handbook of Mixed Methods in social and behavioural research.* Thousand Oaks: Sage.

MAXWELL, J. A. & CHMIEL, M. 2014. *Chapter 37: Generalisations in and from qualitative analysis*.

MCBRIDE, J. & AHMED, R. 2001. Social Franchising as a strategy for expanding access to reproductive health services: A case study of the Green star service delivery in Pakistan. *In:* SERIES, T. P. (ed.) *Commercial Market Strategies.* Washington DC.

MCGREGOR, S. 2008. Neoliberalism and Health Care. *Wileys online Library,* 25.

MCKETHER, W. & FRIESE, S. 2016. Qualitative Social Network Analysis With ATLAS.ti Increasing Power In A Black Community. *Conference: ATLAS.ti user conference 2015.*

MCKETHER, W., GLUESING, J. & RIOPELLE, K. 2009. From Interviews to Social Network Analysis: An Approach for Revealing Social Network Data Embedded in Narrative Data. *Field Methods* 21**,** 154-180.

MCPAKE, B., ASIIMWE, D., MWESIGYE F, OFUMBI, M., STREEFLAND, P. & TURINDE A. 1999. Informal economic activities of public health workers in Uganda: implications for quality and accessibility of care. *Social Science & Medicine,* 49**,** 849-65.

MCPAKE, B., ASIIMWE, D., MWESIGYE F, OFUMBI, M., STREEFLAND, P. & TURINDE A. 2002. Coping strategies of health workers in Uganda. *Studies in Health Services Organisation & Policy,* Vol. 16**,** pp 157-162.

MCPAKE, B. & HANSON, K. 2016. Managing the public-private mix to achieve universal health coverage. *UHC: markets ,profit , and the public good 4.* Lancet.

MCPAKE, B. & NORMAND, C. 2008. *Health Economics: An International Perspective,* London and Newyork, Routledge Taylor and Freancis Group.

MCPAKE, B., NORMAND, C. & SMITH, S. 2013. *Health Economics: An international Perspective,* London and New York, Routledge Taylor and Francis Group.

MCPAKE, B., RUSSO, G., HIPGRAVE, D., HORT, K. & CAMPBELL, J. 2016. Implications of dual practice for universal health coverage. *Bulletin of the World Health Organization,* vol. 94**,** p. 142.

MCPAKE, B., RUSSO, G. & TSENG, F. 2014. How do dual practitioners divide their time? The cases of three African capital cities? *Soc Sci Med,* 122.

MERRIAM, S. B. 1998. *Qualitative research and case study applications in education,* San Francisco CA, Jossey-Bass.

MEUWISSEN, L., GORTER AC & JA., K. 2006. A perceived quality of reproductive care for girls in a competitive voucher programme. A quasi- experiemental intervention study, Managua Nicaragua. *International Journal for quality in Health,* 18**,** 35-42.

MILLER, P. J. 1994. Narrative practices: Their role in socialisation and selfconstruction. *In:* NEISSER U, F. R. (ed.) *The Remembering: Construction and Accuracy in the Self-Narrative.* Cambridge:: CambridgeUniversity Press.

MOFPED 2002. Challenges and prospects for poverty reduction in northern Uganda. Discussion Paper Number 5. . *In:* MINISTRY OF FINANCE, P. A. E. D. (ed.). Kampala: Government of Uganda.

MOH 1998. The Health sub-district strategy. *In:* HEALTH, M. O. (ed.). Kampala, Uganda: Government of Uganda.

MOH 1999. Report on the review of cost sharing(user fees) in government health facilities , Draft Report May 1999. *In:* HEALTH, M. O. (ed.). Kampala, Uganda: Government of Uganda.
MOH 2002. Ministry of Health Uganda (2002) Partnerships in Health Uganda Ministry of Health Online.
MOH 2008. Uganda National Minimum Health Care Activity Package for district Health System by level of care. *In:* HEALTH, M. O. (ed.). Kampala, Uganda: Government of Uganda.
MOH 2010a. Health Sector Strategic and Investment plan (HSSIP) 2010/11-2014/15. *In:* HEALTH, M. O. (ed.). Kampala, Uganda: Government of Uganda.
MOH 2010b. The Second National Health Policy 2010/11 to 2019/20. *In:* UGANDA(MOH)., M. O. H. (ed.). Kampala, Uganda: Government of Uganda.
MOH 2012. National Policy on Public Private Partnership in Health. Kampala: Ministry of Health Uganda,.
MOH 2015. Health Sector Quality Improvement Framework and Strategic Plan 2015/16- 2019/20. *In:* HEALTH, M. O. (ed.). Kampala, Uganda.
MOH 2017. Sector Grant and Budget guideline FY 2017/8. *In:* (MOH), M. O. H. (ed.). Kampala, Uganda: Government of Uganda.
MOH 2019. Proposed National Health Insurance scheme Bill 2019. Kampala: Ministry of Health.
MOH. 1999. National Health Policy 1. *In:* HEALTH, M. O. (ed.). Kampala, Uganda.
MOH. 2014. Annual health Sector Performance report 2014/15. *In:* HEALTH, M. O. (ed.). Kampala, Uganda: Retrieved from https://health.go.ug/sites/default/files/ANNUAL%20HEALTH%20SECTOR%20%20PERFOMANCE%20REPORT.pdf.
MOH., 20/20., H. S. & MAKERERE UNIVERSITY SCHOOL OF PUBLIC HEALTH. 2012. Uganda Health System Assessment 2011. Ministry of Health Uganda(MOH), United States Agency for International development (USAID) and Makerere University School of Public Health. Kampala, Uganda and Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc.
MONTAGU, D. 2015. Universal health coverage and private hospitals are not mutually exclusive. http://www.theguardian.com/global-development/2015/may/18/universal-health-coverage-private-sector-world-health-organisation. *The guardian.Monday 18th May 2015*.
MORGAN, D. L. 2014. *Integrating Qualitative and QuantitativeMethods: A Pragmatic Approach. ,* Thousand Oaks, Sage.
MORGAN, R., ENSOR, T. & WATERS, H. 2016. Performance of Private sector health care: Implications for Universal health coverage. *UHC: Markets, profit and the private good 2.* Lancent.
MUTHAKA, I. D., KIMANI, N. D., MWAURA, S. & MANDA K.D. 2004. A review of the regulatory framework for private health care services in Kenya Social Sector Division Kenya Institute for Public Policy Research and Analysis. KIPPRA Discussion Paper No. 35.

NABUKEERA, M. 2016. Challenges and barriers to health service delivery system in Uganda. *Journal of Nursing and Health Science,* 5**,** 30-38.
NAMAKULA, J., SSENGOOBA, F. & SSALI, S. 2011. Research for Building Pro-poor Health Systems duirng recovery from conflict; Country situation Analysis, Northern Uganda. Kampala: ReBUILD Consortium and Makerere University School of Public Health.

NAMAKULA, J. & WITTER, S. 2014. Living through conflict and post-conflict: experiences of health workers in Northern Uganda and lessons for people-centred health systems. *Health Policy and Planning,* Vol. 29**,** pp. ii6-ii14. Available from: [DOI: 10.1093/heapol/czu022].
NAMAKULA, J., WITTER, S. & SSENGOOBA, F. 2016. Health worker experiences of and movement between public and private not-for-profit sectors—findings from post-conflict Northern Uganda. *Human Resources for Health,* 14.

NATIONAL DRUG AUTHORITY 2019. Licencing Guidelines for drugshops and pharmacies. general notice no. 1321 of 2018. *In:* NATIONAL DRUG AUTHORITY (ed.). Kampala Uganda https://www.nda.or.ug/Linked%20publications/2019%20Licensing%20Guidelines-compressed%20(1).pdf.

NATIONAL DRUG AUTHORITY. 1993. THE NATIONAL DRUG POLICY AND AUTHORITY ACT. CAP 206. *In:* AUTHORITY, N. D. (ed.). Kampala, Uganda.

NATIONAL DRUG AUTHORITY. 2014. National Drug Policy and Authority. Certificate of Suitability of Premises Regulations. 2014 No. 36. Supplement No. 8. *In:* AUTHORITY, N. D. (ed.). Entebbe: UPPC.

NEWBRANDER, W. 2006. Providing health services in fragile states. In: Basic Support for Institutionalising Child Sirvival(BASICS) for the United States Agency for International Development(USAID). Arlington, VA: USAID.

NORTH, C. D. 1994. Institutions and credible commitment. *Economic History*.

OECD 2016. States of Fragility. Paris: Organisations for Economic Cooperation and Development(OECD).

OECD 2018. States of Fragility. Paris: Organisations of Economic Cooperation and Development (OECD).

OKUONZI, S. & MACRAE, J. 1995. 'Whose Policy is it anyway?' International and National Influences on health policy development in Uganda. *Health policy and planning,* 10**,** 122-132.

OMASWA, F. 2006. 'Informal health workers-to be encouraged or condemned?'. *Bulletin of the world Health Organisation,,* 84(2):83.

OVUGA, E., BOARDMAN, J. & OLUKA, E. 1999. Traditional healers and mental illness in Uganda

Psychiatric Bulletin

23**,** 276-279.

OXFAM. 2013. Universal Health Coverage. Why Health Insurance schemes are leaving the poor behind. 176 Oxfam briefing paper. 9 October 2013.

PACHO, T. O. 2015. Exploring participants'experiences of using case studies. *International Journal of Humanities and Social science,* 1.

PAINA, L. 2014. *DUAL PRACTICE IN KAMPALA, UGANDA: A MIXED METHODS STUDY OF MANAGEMENT AND POLICY.* PHD, Johns Hopkins University.

PANSIRI, J. 2005. Pragmatism: A methodological approach to researching strategic alliances in tourism. *Tourism and Hospitality Planning and Development* 2**,** 191-206.

PARKHURST, J. & SSENGOOBA, F. 2009. Assessing access barriers to maternal health care: measuring bypassing to identify health centre needs in rural Uganda. *Health Policy and Planning,* 24**,** 377-384.

PARSONS, A. 2011. Key informants. *In:* LAVRAKAS, P. L. (ed.) *Encyclopedia of Survey Research Methods* Thousand Oaks Sage Publications, Inc.

PATOUILLARD, E., GOODMAN, A., HANSON, K. & MILLS, A. 2007. Can working with the private for-profit sector improve utilisation of quality health services by the poor? A systematic review of the literature. *International Journal for Equity in Health,* 6.

PAULINO, L., ANGELES-AGDEPPA, I., ETORMA, U. & CAVALII- SFORZA, T. 2005. Weekly iron-folic supplementation to imporve iron status and prevent pregnancy anaemia in Filipino women of repreoductive age: the Philippine experience through government and private partnership. *Nutrition Review,* 63**,** 109-115.

PAVIGNANI, E., MICHAEL, M., MURRU, M., BEESLEY, M. & PS., H. 2013. Making sense of apparent chaos: health care provision in six country case studies. *International Review of the Red Cross,* 95**,** 41-60.

PHILLIPS, C. D. & BURBULES, N. 2000. *Post postivisim in educational research,* New York, Oxford, Rowman and Littlefield Publishers.

RACHLIS, M. 2007. Privatised Healthcare won't work. *Privatisation of Health Care. Commisioned Policy research.* Wellesley Institute Advancing Urban Health.

RATNER, C. 2002. Subjectivity and Objectivity in Qualitative Methodology. *forum for qualitative social research,* 3.

REBUILD CONSORTIUM 2018. Program completion Report Liverpool: Liverpool School of Tropical Medicine.

REINIKKA, R. & SVENSSON, J. 2003. Working for God? Evaluating Service Delivery of Religious Not-for-Profit Health Care Providers in Uganda. World Bank.

RITCHIE AND LEWIS. 2003. *Qualitative research practice. A guide for Social Science students and researchers,* London, Sage Publications Ltd.

RITCHIE, J. 2003. The application of Qualitative methods to social research. *In:* RITCHIE, R. A. (ed.) *Qualitative research practice. A guide for social science students and researchers.* London: Sage Publications Ltd.

RITCHIE, J. & SPENCER, E. 1994. Qualitative data analysis for applied policy research. *In:* IN BRYMAN, A. & BURGESS, R. G. (eds.) *(eds).Analysing Qualitative Data.* London, UK: Routledge.

ROBERTS, B., OCAKA, K. F., BROWNE, J., OYOK, T. & SONDORP, E. 2009. "Factors associated with the health status of internally displaced persons in northern Uganda." *Journal of Epidemiology and Community Health,,* 63**,** 227-232.

ROENEN, C., FERRINHO, P., DORMAEL, V. M., CONCEICAO, M. & LERBERGHE, V. W. 1997. How African doctors make ends meet: An exploration. *Tropical Medicine and International Health,* 2**,** 127-135.

ROWLEY, E., ROBIN, A. & HUFF, K. 2006. Health in Fragile States,Country case study: Northern Uganda. Basic Support for Institutionalising Child Survival (BASICS) for the United States Agency for International Development (USAID). Arlington, Virginia USA: USAID.

RUANE, J. M. 2005. *Essentials of research methods: A guide to social science research.* , Blackwell Publishing.

RUSSO, G., FRONTEIRA, I., JESUS, S. & BUCHAN, J. 2018. Understanding nurses' dual practice: a scoping review of what we know and what we still need to ask on nurses holding multiple jobs *Human Resources for Health,* 16.

RUSSO, G., MCPAKE, B., FRONTEIRA, I. & FERRINHO, P. 2013. Negotiating markets for health: an explorationof physicians' engagement in dual practice in three African capital cities. *Health policy and planning*.

RUTEBEMBERWA, E., PARIYO, G., PETERSON, S., THOMSON, G. & KALLANDER, K. 2009. Utilisation of public or private health care providers by Febrile children after user fee removal in Uganda. *Malaria Journal,* Vol. 45**,** [online] Available from: http://www.malariajournal/8/1/45

SARA 2005. Tool kit to imporve private provider contributions to child health. Washington DC: United States Agency for International Development (USAID).

SHAREIA, B. 2015. The Qualitative Case Study Research in Accounting: Challenges and Prospects-The Libyan case study. *International Journal of Social, Management, Economics, and Business Engineering,* 9**,** 3873-3877.

SILVERMAN, D. 2005. *Doing Qualitative research. 2nd Edition. ,* London, Sage Publications Ltd.

SIMONS, H. 2009. *Case study research in practice,* London, SAGE.

SMITH, E., BRUGHA, R. & ZWI A. 2001. Working with private sector providers for better health care: an introductory guide. . London Options and London School of Hygiene and Tropical Medicine.

SSALI, S. 2018. Neoliberal healh reforms and citizenship in Uganda. *In:* WIEGRATZ, J., MARTINIELLO, G. & GRECO, E. (eds.) *In Uganda: A Neoliberal transformation.* The Foundry, 17 Oval way, London, SE11 5RR, UK: Zed Books.

SSALI, S., BYABASHEIJA, R. & MUGABE, P. 2011. Analysing patterns in household health expenditure in Gulu district, Northern Uganda (1989-2010): A research protocol. ReBUILD Consortium and Makerere University, School of women and gender studies and School of Public Health.

SSALI, S., THEOBALD, S., NAMAKULA, J. & WITTER, S. 2016. Building post-conflict health systems: a gender analysis from Northern Uganda. Chapter 20 *In:* ELGAR (ed.) *Gender and Health Handbook. Elgar online. Available from: https://www.elgaronline.com/view/9781784710859.*

SSENGOOBA, F., KAWOOYA, V., NAMAKULA, J. & FUSTUKIAN, S. 2017. Application of Social network Analysis in the assessment of organisation infrastructure for service delivery: A three district case study from post conflict Northern Uganda. *Health Policy and Planning* 32**,** 1193–1202. .

SSENNYONJO, A., NAMAKULA, J., KASYABA, R., ORACH, S., BENNETT, S. & SSENGOOBA, F. 2018. Government resource contributions to the private-not-for-profit sector in Uganda: evolution, adaptations and implications for universal health coverage. *International Journal for Equity in Health,* 13.

STAKE, E. R. 1995. *The art of case study research.*, Thousand Oaks, CA. Sage publications.

STIGLITZ, J. 2002. *Globalisation and its discontents,* United States, W.W Norton and Company.

SUDHINARASET, M., INGRAM, M., KINLAW, H. L. & MOTANGU, D. 2013. What is the role of informal health providers in developing countries? A Systematic Review. *PLOS ONE 8(9): 10 [online]. Available from: http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0054978*.

SWEENEY, M. N. 2009. Private- Sector Development in Post- Conflict Countries. A review of current Literature and Practice. Cambridge, UK: Donor Commitee for Entreprise Development(DECD).

TASHAKKORI, A. & TEDDLIE, C. 1998. Mixed Methodology: Combining Qualitative and Quantitative Approaches. *Applied Social Research Methods Series 46.* Thousand Oaks: Sage Publications.

TASHAKKORI, A. & TEDDLIE, C. 2008. *Mixed Methodology: Combining Qualitative and Quantitative Approaches.,* Thousand Oaks, Sage Publications.

TASHOBYA, C. K., OGORA, V. A., KIWANUKA, N. S., MUTEBI, A., MUSILA, T., BYAKIKA, S. & SSENGOOBA, F. 2018. Decentralisation in Uganda Health System: What can we learn from past experiences to facilitate achievement of Universal Health Coverage? Chapter 6. *In:* SSENGOOBA, F., KIWANUKA, N., SUZANNE.,, RUTEBEMBERWA, E. & EKIRAPA- KIRACHO, E. (eds.) *Universal Health Civerage in Uganda. Looking back and forward to speed up progress.* Kampala, Uganda: Makerere University School of Public Health.

THOMSON, M., KENTIKENELIS, A. & STUBBS, T. 2017. "Structural adjustment programmes adversely affect vulnerable populations: a systematic-narrative review of their effect on child and maternal health. *Public health reviews,* 38.

THORSEN, D. 2009. The Neoliberal Challenge. What is Neoliberalism? University Of Oslo.

TUMWESIGYE, T. 2013. Health services delivery by PNFP subsector in Uganda: The case of Medical Bureaus.: Uganda Protestant Medical Bureau(UPMB).

UBOS 2013. Gulu district statistical abstract 2012/13. *In:* (UBOS, U. B. O. S. (ed.). Accessed from: http://www.ubos.org/onlinefiles/uploads/ubos/2009_HLG_%20Abstract_printed/CIS+UPLOADS/Higher%20Local%20Government%20Statistical%20Abstracts_2014/Gulu.pdf.

UBOS 2016a. Uganda National Household Survey report 2016/17. *In:* STATISTICS(UBOS), U. B. O. (ed.). Kampala, Uganda: Uganda Bureau of Statistics.

UBOS 2016b. Uganda Demographic Health Survey 2016. Kampala, Uganda: Uganda Bureau of Statistics (UBOS).

UBOS 2018. Statistical Abstract *In:* STATISTICS(UBOS)., U. B. O. (ed.). Kampal, Uganda.

UGANDA MEDICAL AND DENTAL PRACTIONERS COUNCIL. 1998. Medical and Dental Practioners Act 1998 Chapter 272. Kampala, Uganda.

UKPCDP 2013. Annual review for UK Post- conflict Development Programme for Northern Uganda (UKPCDP). UK Department for International development. [online] Available from: iati.dfid.gov.uk › iati_documents.

UPLEKAR, M., MORANKAR, S., RANGAN, S. & NUNN P. 1998. Tuberculosis patients and practitioners in private clinics in India. *International Journal of Tuberculosis and Lung Disease,* 2**,** 324-329[online] Available at: http://www.equityhealthj.com/pubmed/9559404. [viewed October 15th 2014].

VAN DER RIET, M. 2008. *Participatory Research and the Philosophy of Social Science*, Sage Publications.

VAN ROSSEM, R. & MEEKERS, D. 2000. An evaluation of the effectiveness of targeted socia marketing to promote adolescent and young adult reporductive health in Cameroon. *AIDS education prevention,* 12.

VONG, S., RAVEN, J. & NEWLANDS, D. 2018. Internal contracting of health services in Cambodia: drivers for change and lessons learned after a decade of external contracting. *BMC Health Services Research,* 18**,** 375.

WANG, W., TEMSAH, G. & MALLICK, L. 2017. The impact of Health insurance on maternal health care utilisation: Evidence from Ghana, Indonesia and Rwanda. *Health policy and planning,* 32**,** 366-375.

WASSERMAN, S. & FAUST, K. 1994. *Social Network Analysis: Methods and applications. ,* Cambridge,UK, Cambridge University Press.

WATERS, H., HATT, L. & H.D., P. 2003. Working with the private sector for child health. *Health policy and planning,* 18**,** 127-137.

WELCH, C., PIEKKARI, R., PLAKOYIANNAKI, E. & PAAVILAINEN-MÄNTYMÄKI, E. 2011. Theorising from case studies: Towards a pluralist future for international business research. *Journal International Business Studies,* 42**,** 740-762.

WELLMAN, B. & BERKOWITZ, S. 1988. *Social structures: A Network Approach. ,* Cambridge, UK, Cambridge University Press.

WHELAN, J. & MSEFER, K. 1996. Economic demand and supply. MIT Systems dynamics in Education project.

WHO 1946. Constitution of the World Health Organization. *In:* ORGANIZATION., W. H. (ed.). New York: World Health Organization

WHO 2010a. WHO Gobal Health Expensiture Atlas. Geneva: World Health Organisation.

WHO 2010b. World Health Report 2010. Health systems financing: The Path to Universal Coverage. Geneva: World Health Organisation.

WHO 2013. Arguing for Universal health Coverage. Geneva: World Health Organisation.

WHO 2014. WHO traditional medicine strategy 2014-2023. . Geneva: World Health Organisation WHO.

WHYTE, S. 1991. Medicines and self-help: the rpivatisation of healht care in eastern Uganda. . *In:* HANSEN HB (ed.) *Changing Uganda, the dilemma of structural adjustment and revolutionary change.* London: James Curry.

WHYTE, S. 1992. Pharmaceuticals as folk medicine: transformation in socia relations in health care in Uganda. *Cultural and medical Psychiatry,* 16**,** 163-86.

WIEGRATZ, J., MARTINIELLO, G. & GRECO, E. 2018. *Uganda: The Dynamics of Neoliberal Transformation,* The foundry 17 Oval way, London SE11 5RR,UK, Zed Books Ltd.

WILLIAMSON, E. O. 1981. The Economics of Organisation: The transaction cost approach. *American Journal of Sociology,* 87**,** 548-577.

WILLIAMSON, J. 2004. 'A Short History of the Washington Consensus'paper commissioned by Fundacion CIDOB for the conference. *'From the Washington Consensus towards a new Global Governance',*. Barcelona.

WITTER, S. 2012. Health financing in fragile and post-conflict states: what do we know and what are the gaps? . *Social Science and Medicine,* 75**,** 2370–2377.

WITTER, S., BERTONE, M., NAMAKULA, J., CHANDIWANA, P., CHIRWA, Y., SSENYONJO, A. & SSENGOOBA, F. 2019. (How) does RBF strengthen strategic purchasing of health care? Comparing the experience of Uganda, Zimbabwe and the Democratic Republic of the Congo. *Global Health Research and Policy,* 4.

WITTER, S., WURIE, H., CHANDIWANA, P., NAMAKULA, J., SO, S., ALONSO- GARBAYO, A., SSENGOOBA, F. & RAVEN, J. 2017. How do health workers experience and cope with shocks? Learning from four fragile and conflict-affected health systems in Uganda, Sierra Leone, Zimbabwe and Cambodia. *Health policy and planning,* 32**,** iii3-iii13.

WORLD BANK 1993. The World Bank annual report (English). Washingtion, DC: World Bank.

WORLD BANK 2016. The Uganda Poverty assessement Report 2016. Frams, cities and good fortune: Assessing poverty reduction in Uganda from 2006 to 2013. Report no. ACS18391. The World Bank group.

WORLD BANK. 2003. Private Sector Assessment for Health, Nutrition and Population (NHP) in Bangladesh, Report no. 27005-BD,. Washington, DC.: World Bank.

WORLD BANK. 2016. Somaliland's Private Sector at a Crossroads: Political Economy and Policy Choices for Prosperity and Job Creation. World Bank Studies. Washington, DC: World Bank. doi:10.1596/978-1-4648-0491-5.

WORLD VISION. 2009. Annual End of project report: Livelihood Recovery project, Pader district, World Vision Uganda. World Vision, Uganda.

WORLDBANK 2005. Anarchy and Invention. How does Somalia's private sector cope without Government. *Private Sector and Infrastructure.* WorldBank.

WORLDBANK 2016. Doing Business 2016: Measuring Regulatory Quality and Efficiency. http://www.doingbusiness.org/-/media/GIAWB/Doing%20Business/Document/Annual-Reports/English/DB16-Full-Report.pdf. Washington DC: World Bank.

YIN, R. K. 2003. *Applications of case study research. 2nd ed. Applied Social research Methods series. Volume 34,* London , New Delhi., Sage Publications, Thousand Oaks.

YIN, R. K. 2009. *Case study research design and methods. 4th Ed*, Sage Publications, Thousand Oaks.

APPENDICES

Appendix 1: Consent Form for Managers or health workers participating in the mini- organisational survey of Formal Private for- Profit organisations in Gulu

Study title: Health care markets in post conflict settings: Experiences of formal Private for-Profit health care organisations in Gulu district, Northern Uganda
Makerere University School of Public Health, ReBUILD Consortium

My name is Justine Namakula, a research fellow working on ReBUILD project at Makerere University School of Public Health, Mulago Kampala. I am also a PhD student at Queen Margaret University Edinburgh. I am interested in learning about the experiences of Formal Private for- Profit organisations (FPFP) in Gulu, particularly during and after the conflict that ended in 2006. This will help me, and policymakers understand contribution of FPFP to health service delivery in Gulu as well as challenges they face. The research is for academic purposes and will contribute to my PhD.

Whereas I will plan to have detailed interviews at a later stage, I would like to first conduct a survey of all the FPFPs in Gulu in order to get a general understanding of their characteristics. Your organization has been identified using a list of all FPFPs which was provided to me by the district office. I am looking for managers of these FNFPs or any person that may be assigned by the manager to participate in this survey on behalf of the organization.

If you agree to participate, I would like to discuss a few issues about your organisation. The questionnaire consists of issues such as date of establishment and registration of the organization, category of organization, main purpose, operating hours, major services offered, number of staff and categories, level of education and relationship with other providers as well as development partners. Your opinions will be taken as the opinions of your organization in this study. I am going to take notes.

The information you provide will be kept in strict confidence and will not be shared with any other person. Your name will not be used in the reports or publications that will arise from this study. If the name of your organization is identifiable in the publications, the research team will uphold the principle of “do no harm” in regard to the information associated with the organization.

Participation is voluntary. You are free to decline answering questions you do not feel comfortable about. You can stop the interview at any time. However, your participation, response to the questionnaire and provision of many as many answers as possible will be greatly appreciated. The interview should take between 30-45 minutes of your time.

If you have any concerns about the study you can ask me to explain more or contact the following: Dr John Sempebwa Chairman Ethics Review Committee, Makerere University, School of Public Health, Tel: 0414 543872.

Would you like to volunteer answers to this study? Yes No

Participant’s Signature _____ Date_____

Witness’ Signature _____ Date_____

Appendix 2: Consent form for District health team members, Managers and health workers of Private not- for-profit facilities and Public health facilities in Gulu, Representatives of donor agencies, Representatives of association bodies in Gulu and at national level

Study title: Health care markets in post conflict settings: Experiences of formal Private for-Profit health care organisations in Gulu district, Northern Uganda Makerere University School of Public Health, ReBUILD Consortium

My name is Justine Namakula, a research fellow working on ReBUILD project at Makerere University School of Public Health, Mulago Kampala. I am also a PhD student at Queen Margaret University Edinburgh. I am interested in learning about the experiences of Formal Private for- Profit organisations (FPFP) in Gulu, particularly during and after the conflict that ended in 2006. This will help me, and policymakers understand contribution of FPFP to health service delivery in Gulu as well as challenges they face. The research is for academic purposes and will contribute to my PhD. This research seeks to understand the process and history of your organisation and how it responded to the challenges of the conflict and its growth since then. You have been purposively selected to participate in this study because you are one of the stakeholders contributing to health service provision and development in Gulu district.

If you agree to participate, I would like to discuss a few issues. I would like to ask about your perception of the role of the private for-profit sector in general. I would also like you to comment on what you think the challenges and opportunities of the FPFPs. I would also like you to tell me about the relationship between your organisation and the FPFPs. I would also like to know if there are any ways you engage with the FPFPs to enable the provision of health services for the poor people in Gulu district.

I am going to take notes. However, with your permission, I would also like to use a tape recorder to enable me to capture all the information that I would have missed out during note taking. The information you provide will be kept in strict confidence and will not be shared with any other person. Your name will not be used in the reports or publications that will arise from this study. If the name of your organization is identifiable in the publications, the research team will uphold the principle of "do no harm" in regard to the information associated with the organization. Participation is voluntary. You are free to decline answering questions you do not feel comfortable about. You can stop the interview at any time. However, your participation and provision of your opinions will be greatly appreciated. The interview will take between 45 Minutes and one hour of your time.

If you have any concerns about the study you can ask me to explain more or contact the following: Dr John Sempebwa Chairman Ethics Review Committee, Makerere University, School of Public Health, Tel: 0414 543872. **Would you like to volunteer answers to this study? Yes No**

Participant's Signature_____Date _____

Witness' Signature _____Date _____

Appendix 3: Consent form for Managers and health workers of the selected Formal private for- Profit organisations in Gulu participating in Life histories and In-depth interviews

Study title: Health care markets in post conflict settings: Experiences of formal Private for-Profit health care organisations in Gulu district, Northern Uganda

Makerere University School of Public Health, ReBUILD Consortium

My name is Justine Namakula, a research fellow working on ReBUILD project at Makerere University School of Public Health, Mulago Kampala. I am also a PhD student at Queen Margaret University Edinburgh. I am interested in learning about the experiences of Formal Private for- Profit organisations (FPFP) in Gulu, particularly during and after the conflict that ended in 2006. This will enable policymakers and I to understand contribution of FPFP to health service delivery in Gulu as well as challenges they face. The research is for academic purposes and will contribute to my PhD. This research seeks to understand the process and history of your organisation and how it responded to the challenges of the conflict and its growth since then.

Your organization is purposively selected based on the criteria that it is a Formal Private for-Profit organization (FPFP), which is the focus of this study; it was either established during the conflict and four that were established after the conflict. I am looking for seven managers who have worked with their organisations since they were established. If you agree to participate, I would like to discuss a few issues about your organisation. Particularly, I would like you to elaborate on when this organisation was established, who the founding members were, what you perceive as the most important events in the life of this organisation, the challenges and how they were overcome as well as the opportunities that have come your way and how the organisation has tried to make use of them. In general, I would also like you to tell me about the relationship between your organisation and other providers and your perception of the general contribution of this organisation to the health of the people in Gulu.

I am going to take notes. However, with your permission, I would also like to use a tape recorder to enable me to capture all the information that I would have missed out during note taking.The information you provide will be kept in strict confidence and will not be shared with any other person. Your name will not be used in the reports or publications that will arise from this study. If the name of your organization is identifiable in the publications, the research team will uphold the principle of "do no harm" regarding the information associated with the organization. Participation is voluntary. You are free to decline answering questions you do not feel comfortable about. You can stop the interview at any time. However, your participation and provision of your opinions will be greatly appreciated. The interview will take between $1^1/_2$ hours and 2 hours of your time.

If you have any concerns about the study, you can ask me to explain more or contact the following: Dr John Sempebwa Chairman Ethics Review Committee, Makerere University, School of Public Health, Tel: 0414 543872.

Would you like to volunteer answers to this study? Yes No

Participant's Signature _____ date _____

Witness' Signature _____date _____

Appendix 4: Survey questionnaire

STRICTLY CONFIDENTIAL
HEALTH CARE MARKETS IN POST CONFLICT SETTINGS: EXPERIENCES OF FORMAL PRIVATE FOR-PROFIT HEALTH CARE ORGANISATIONS IN GULU DISTRICT, NORTHERN UGANDA

IDENTIFICATION ORGANISATION ID (four digits):
INTERVIEWER'S NAME:

INTERVIEW DATE:
LOCATION OF ORGANISATION (Street name/ name of the road):

SECTION 1: SOCIO-DEMOGRAPHICS OF THE ORGANISATION			
NO	**QUESTIONS**	**CODING CATEGORIES**	**SKIPS**
1.1	Sex of respondent **(*Don't ask, just indicate)***	1. Male 2. Female	
1.2	When was this organisation established?	Month_____ Year: _____	
1.3	How many years has this organisation spent in existence?	☐☐ Years/months	
1.4	In which year was this organisation registered? ***(write one number in each box)***	☐☐☐☐	
1.5	To what category does this organisation belong **(*Circle only one option*)**	1. Clinic 2. Medical centre 3. Pharmacy 4. Laboratory 5. Private Hospital 6. Insurance Company Clinic **7.** Other (Please specify) _____	
1.6	Does this organisation have a written mission statement?	1.Yes 2.No	**IF NO, SKIP TO QN 1.8**
1.7	What is the main purpose of this organisation?	_____ _____ _____	
1.8	What are the operating hours of this organisation? ***(Circle any two that apply)***	1. Open less than 12 hours a day 2. Open 12 hours a day 3. Open 24 hours 4. Open Monday to Friday only 5. Open every day of the week	
1.9	Does this facility admit patients to stay overnight	1.Yes 2.No	**IF NO, SKIP TO QN 1.11**

1.10	How many admission beds does this organisation have? (***Circle only one)***	1. None 2. 6 and below 3. Between 7 and 15 beds 4. Between 16- 24 beds 5. Between 24and 50 beds- 6. Above 50	
1.11	What are the **major** services offered by this organisation? ***(Circle all that apply)***	1.Dentistry 2. Sale of drugs only 3. X-ray services 4. Consultation 5.Prescription of drugs and medicine 6. Family planning services 7. Maternal deliveries 8. Major surgeries 9. Minor surgeries 10. Blood tests 11. Ear nose and throat related services 12. Eye clinic 13. Laboratory 14. Other (Please specify) _____	
1.12	Which of the services in 1.11 above is your organisation **best known** for among people in Gulu district? *(**Circle any three that apply)***	1.Dentistry 2. Sale of drugs only 3. X-ray services 4. Consultation 5.Prescription of drugs and medicine 6. Family planning services 7. Maternal deliveries 8. Major surgeries 9. Minor surgeries 10. Blood tests 11. Ear nose and throat related services 12. Eye clinic 13. Laboratory 14.Other (Please specify) _____	
1.13	Who are the users of these services? ***(Circle all that apply)***	1. Elderly people 2. People with disabilities 3. Pregnant women from the slums in Gulu 4. Employees of NGOs in Gulu 5. Households in Gulu slums 6. Formerly abducted youth 7. People living with HIV/ AIDS 8. Child mothers 9. Adolescents 10. Other (Please specify) _____	

		_____	
1.14	Do you have a fee exemption policy?	1. Yes 2. No	**IF NO, SKIP TO QN 1.17**
1.15	If **yes** in 1.13, which of the services does the fee exemption policy apply? ***(Circle all that apply)***	1. Dentistry 2. Sale of drugs only 3. X-ray services 4. Consultation 5.Prescription of drugs and medicine 6. Family planning services 7. Maternal deliveries 8. Major surgeries 9. Minor surgeries 10. Blood tests 11. Ear nose and throat related services 12. Eye clinic 13. Laboratory 14. Other (Please specify) _____	
1.16	For which categories of people does the exemption fee policy apply? ***(Circle all that apply)***	1. Elderly people 2. People with disabilities 3. Pregnant women from the slums in Gulu 4. Employees of NGOs in Gulu 5. Households in Gulu slums 6. Formerly abducted youth 7. People living with HIV/ AIDS 8. Child mothers 9. Adolescents 10. Other (Please specify) _____ _____	
1.17	Do you have a fee reduction policy?	1.Yes 2.No	**IF NO, SKIP TO NEXTSECTION**
1.18	If **yes** in **1.17**, which of the services does the fee reduction policy apply? ***(Circle all that apply)***	1. Elderly people 2. People with disabilities 3. Pregnant women from the slums in Gulu 4. Employees of NGOs in Gulu 5. Households in Gulu slums 6. Formerly abducted youth 7. People living with HIV/ AIDS 8. Child mothers 9. Adolescents 10. Other (Please specify)	

NO	QUESTIONS	CODING CATEGORIES	SKIPS
2.1	How many staff are employed by this organisation? ***(State actual number**)*	_____	
2.2	What is the highest level of education completed by staff employed in this organisation?*)* ***(Circle all that apply)***	1. None 2. Primary 3. Secondary 4. University 5. Vocational institute 6. Other (Please Specify) _____	

2.3.	Please indicate number of staff per category circled in 2.2 above	1. None 2. Primary 3. Secondary 4. University 5. Vocational institute 6. Other (Please Specify) _____	---------- ---------- ---------- --------- _____ _____	
2.4	Does your organisation have any of the following cadres of staff? **(*Put tick against Yes if available and tick against No if category is not available)***	1. Medical doctor 2. Surgeon 3. Radiologist 4. Enrolled Nurse 5. Registered Nurse 6. Enrolled midwife 7. Registered midwife 8. Radiologist 9. Laboratory assistant	Yes___ NO___ Yes___ NO___ Yes___ NO___ Yes___ NO___ Yes___ NO___ Yes___ NO___ Yes___ NO___ Yes___ NO___ Yes___ NO___	
2.5	Indicate sex of Manager of facility	1. Male 2. Female		
2.6	What is the highest education level completed by the manager/ In-charge of this organisation? **(Circle only one option)**	1. None 2. Primary 3. Secondary 4. University 5. Vocational Institute 6. Other (Please Specify) _____ _____		
2.7	Do you have any staffs who work here part time?	1. Yes 2. No		

SECTION 3: RELATIONSHIP WITH OTHER PROVIDERS AND HEALTH DEVELOPMENT PARTNERS

NO	QUESTIONS	CODING CATEGORIES	SKIPS
3.1	Is this organisation connected to any other health providers within Gulu district?	1. Yes 2. No	**IF NO END INTERVIEW**
3.2	Which types of organisations is this organisation connected with **(circle codes for organisations)?**	Clinics 11 Medical Centres 12 Pharmacies 13 Laboratories 14	

	Multiple responses apply	Private for-profit hospitals 15 Insurance Company Clinic 16 Public hospital 17 Public Health facility…… 18 Private not-for-profit 19 NGO ……19 Donor agency ……..20 Other non-registered health provider (Please specify) _____21	
3.3	What is the relationship between your organisation and the organisations in question **3.2** above? (Circle all relationships that apply and give at least two names or organisations)	**Relationship** 1.We refer patients to them 2. They refer patients to us 3.Funding source 4. Regulation and support supervision 5.Inspection 6.Information exchange 7. Some of our staff work there too 8.Some of their staff work here too 9.Membership) 10. Other (Please specify)	**Name(s) of organisation** _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

END OF INTERVIEW. THANK YOU FOR YOUR TIME

Appendix 5: Organisational Life-history interview: interview guide

Please can you help draw a line on this paper indicating the key events that happened in this business since it was established?

1. **Initiation and structure of the organisation**

Probes:

In what year did the organisation come into being?
What caused its creation?
Who was the main source of support in the creation?
What was the original source of funding?
What was the early orientation of the organisation?
What was the organisation's main leadership and membership structure?

2. **Organisational evolution**

Probes:

How has the organisation changed since the early days?
What were the events that led to these changes?
What are the accomplishments?
What are the challenges and how have they been overcome? Which challenges were not overcome?
What have been the opportunities along the organisations' life span?
How has the organisation positioned itself to harness the available opportunities e.g. donor funding, contracting e.t.c?

3. **Relationship to associations and networks**

Probe for:

Any collaborations with other providers in the neigbourhood
Membership ofan umbrella organisation, regional network, national network or international
Relationship with other providers
Relationship with the district, State
Nature of relationship (is it formal or informal)?
Overall, how have these relationships and collaborations with others played an important role in the target organisation's life history?

4. **Mechanisms to ensure access for the poor and equity**

Are there any mechanisms in this organization that enable the poorest to access health care?
If so, please give examples
Briefly explain source of funding for these mechanisms/ initiatives
Briefly explain how each was implemented,
In your opinion, what impact have these mechanisms had on number of people accessing health care in your facility
In your opinion, what impact have these mechanisms made on the general image of your organisation

Appendix 6: Key informant guide and In-depth interview guide

1. In general, tell me about your view of the private for-profit health sector? ***Probe*** *for views on roles, a brief on how they have evolved in the area (depending on how long the key informant has worked in the region*
2. In what ways is your organisation related to the private for health provider? ***Probe*** *for referrals, information exchange, human resource sharing, equipment, training, regulation, funding and personal links to the FPFP among other aspects. Probe for names of the facilities that are related to the respondents' own*
3. *What challenges have you faced in your role?*
4. *Please tell me about any mechanisms that you are aware of that are being implemented by the private for-profit to ensure that the poor access health care.*
5. *In your opinion, what are the challenges and opportunities for the private for-profit health care in Gulu?*

Appendix 7: Observation guide/checklist

Name of FPFP:
Physical structure (size and quality)

Signpost (Range of services offered)

Posters around the facility

Location and nearby surroundings

Interaction between the health workers in the FPFPs and their clients

General (SOPs)

Cleanliness

General advertisement mechanisms used to attract clients and direct clients

AOB

Appendix 8: Clearance from QMU

Queen Margaret University
EDINBURGH

Lucy Clapson
Secretary to Research Ethics Panel
Queen Margaret University, Edinburgh
Queen Margaret University Drive
Musselburgh
East Lothian EH21 6UU

Tel (0)131 474 0000 Fax (0)131 474 0001
Email: researchethics@qmu.ac.uk

Justine Namakula
IIHD
School of Health Sciences

19 February 2015

Dear Justine,

Ethical Approval - Health care markets in post-conflict settings: Experiences of formal private for - profit health care organisations in Gulu district, Northern Uganda

I am writing to confirm that Dr Suzanne Fustukian, as Acting Head of IIHD, has granted ethical approval for the above named study.

Yours sincerely,

Lucy Clapson
Secretary to the Research Ethics Panel

DIVISION OF GOVERNANCE AND QUALITY ENHANCEMENT
QUEEN MARGARET UNIVERSITY, EDINBURGH
MUSSELBURGH
EAST LOTHIAN EH21 6UU

Appendix 9: Clearance from Makerere University Higher degrees

MAKERERE UNIVERSITY

P.O. Box 7072 Kampala Uganda
Website: www.musph.ac.ug

Tel: *256 414 532207/543872/543437*
Fax: *256 414 531807*

COLLEGE OF HEALTH SCIENCES
SCHOOL OF PUBLIC HEALTH
HIGHER DEGREES, RESEARCH AND ETHICS COMMITTEE

23rd March, 2013

Justine Namakula
Principal Investigator, Protocol (279)
Makerere University, School of Public Health

Expedited review,

Re: Approval of Proposal titled: Health care markets in post-conflict settings: Experiences of formal private for – Profit Health Care Organisations in Gulu district, Northern Uganda (HDREC 279)

This is to inform you that, the Higher Degrees, Research and Ethics Committee (HDREC) has granted approval to the above referenced study, the HDREC reviewed the proposal and made some suggestions and comments which you have adequately incorporated:

Note that the initial approval date for your proposal by HDREC is 23rd/03/2015, and therefore approval expires at every annual anniversary of this approval date. The current approval is therefore valid until: 23rd/03/2016.

Continued approval is conditional upon your compliance with the following requirements:

1) No other consent form(s), questionnaire and/or advertisement documents should be used. The consent form(s) must be signed by each subject prior to initiation of any protocol procedures. In addition, each subject must be given a copy of the signed consent form.

2) All protocol amendments and changes to other approved documents must be submitted to HDREC and not be implemented until approved by HDREC except where necessary to eliminate apparent immediate hazards to the study subjects.
3) Significant changes to the study site and significant deviations from the research protocol and all unanticipated problems that may involve risks or affect the safety or welfare of

Makerere University School of Public Health
Valid Thru:
23 MAR 2016
Higher Degrees, Research and Ethics Committee

subjects or others, or that may affect the integrity of the research must be promptly reported to HDREC.

4) All deaths, life threatening problems or serious or unexpected adverse events, *whether related to the study or not,* must be reported to HDREC in a timely manner as specified in the National Guidelines for Research Involving Humans as Research Participants.

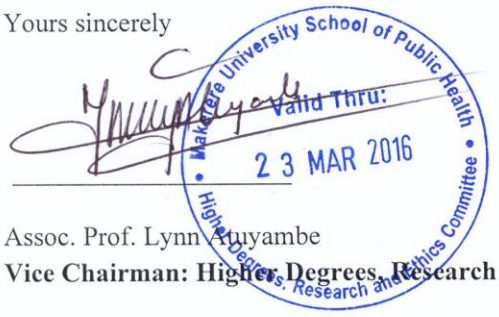
- Please complete and submit reports to HDREC as follows:

a) For renewal of the study approval – complete and return the continuing Review Report – Renewal Request (Form 404A) at least 60 days prior to the expiration of the approval period. The study cannot continue until re-approved by HDREC.

b) Completion, termination, or if not renewing the project – send a final report within 90 days upon completion of the study.

- Finally, the legal requirement in Uganda is that all research activities must be registered with the National Council of Science and Technology. The forms for this registration can be obtained from their website www.uncst.go.ug. Please contact the Administrative Assistant of the Higher Degrees, Research and Ethics Committee at wtusiime@musph.ac.ug or telephone number (256)-41-543872 or + (256)772-496-136 if you encounter any problems.

Yours sincerely

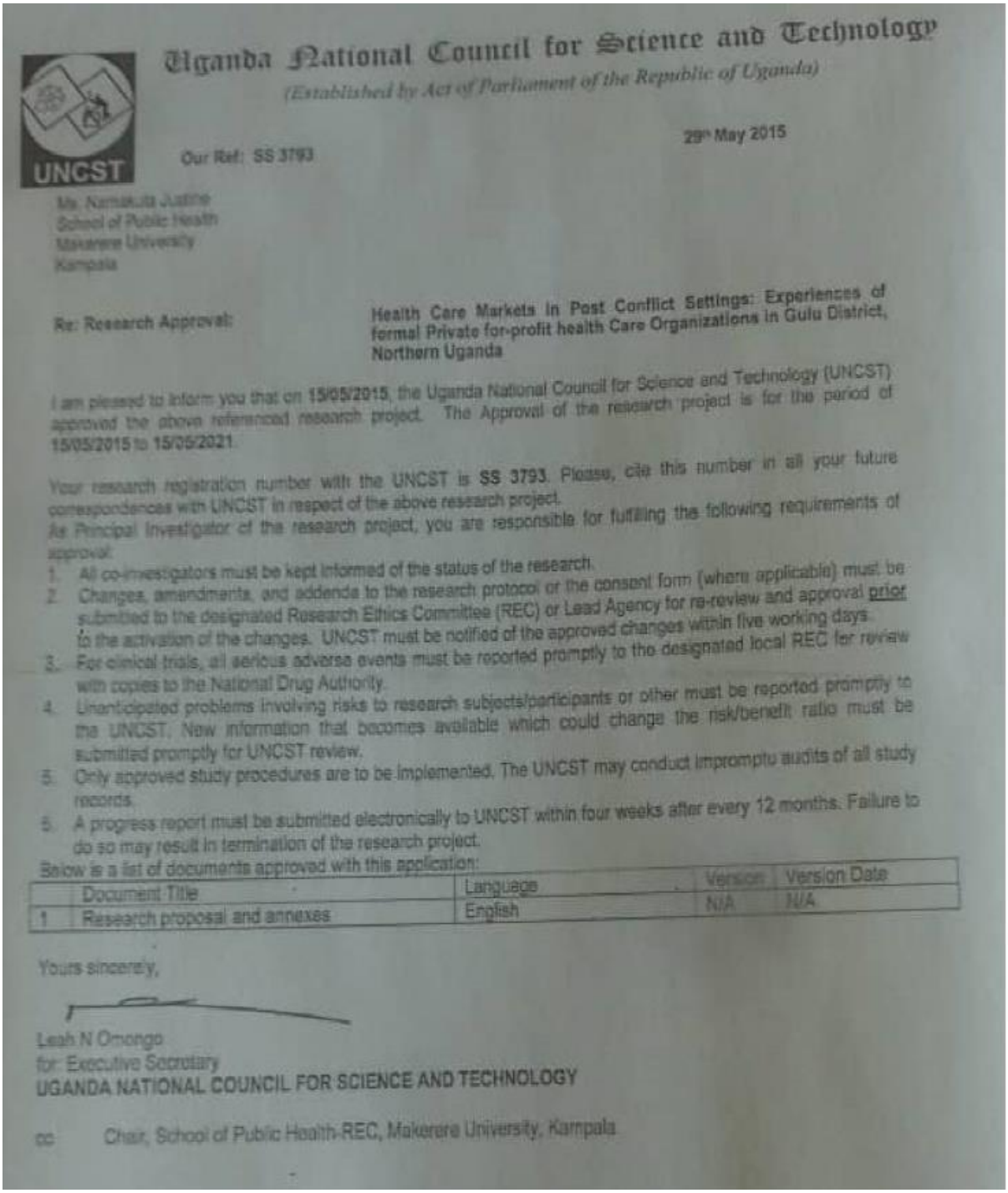


Assoc. Prof. Lynn Atuyambe
Vice Chairman: Higher Degrees, Research and Ethics Committee

Enclosures:

a) A stamped, approved study documents (informed consent documents):

Appendix 10: Clearance Letter from Uganda National Council for Science and Technology (UNCST)



Uganda National Council for Science and Technology

(Established by Act of Parliament of the Republic of Uganda)

UNCST

Our Ref: SS 3793

29th May 2015

Ms. Namakula Justine
School of Public Health
Makerere University
Kampala

Re: Research Approval: **Health Care Markets in Post Conflict Settings: Experiences of formal Private for-profit health Care Organizations in Gulu District, Northern Uganda**

I am pleased to inform you that on **15/05/2015**, the Uganda National Council for Science and Technology (UNCST) approved the above referenced research project. The Approval of the research project is for the period of **15/05/2015** to **15/05/2021**.

Your research registration number with the UNCST is **SS 3793**. Please, cite this number in all your future correspondences with UNCST in respect of the above research project.

As Principal Investigator of the research project, you are responsible for fulfilling the following requirements of approval:

1. All co-investigators must be kept informed of the status of the research.
2. Changes, amendments, and addenda to the research protocol or the consent form (where applicable) must be submitted to the designated Research Ethics Committee (REC) or Lead Agency for re-review and approval prior to the activation of the changes. UNCST must be notified of the approved changes within five working days.
3. For clinical trials, all serious adverse events must be reported promptly to the designated local REC for review with copies to the National Drug Authority.
4. Unanticipated problems involving risks to research subjects/participants or other must be reported promptly to the UNCST. New information that becomes available which could change the risk/benefit ratio must be submitted promptly for UNCST review.
5. Only approved study procedures are to be implemented. The UNCST may conduct impromptu audits of all study records.
6. A progress report must be submitted electronically to UNCST within four weeks after every 12 months. Failure to do so may result in termination of the research project.

Below is a list of documents approved with this application:

	Document Title	Language	Version	Version Date
1	Research proposal and annexes	English	N/A	N/A

Yours sincerely,

Leah N Omongo
for: Executive Secretary
UGANDA NATIONAL COUNCIL FOR SCIENCE AND TECHNOLOGY

cc Chair, School of Public Health-REC, Makerere University, Kampala

Appendix 11: Introduction letter to the district

MAKERERE UNIVERSITY

P.O. Box 7072 Kampala Uganda
Email: hppm@musph.ac.ug

Tel: +256-41-4-543872/530291
Fax: +256-41-4-531807/540633
Website: http://www.musph.ac.ug

COLLEGE OF HEALTH SCIENCES
SCHOOL OF PUBLIC HEALTH
Department of Health Policy Planning and Management

7th April 2015

To: ……..
……..

Dear Sir/Madam,

Re: Introduction for Ms. Justine Namakula

This letter serves to introduce to you Ms. Justine Namakula who has been cleared to conduct research in Gulu by Makerere University Higher Degrees research and Ethics Committee (HDREC). Ms. Namakula is a Research Fellow at the Makerere University School of Public Health and also a PHD student Queen Margaret University, Edinburgh. Queen Margaret University is one of the participating Universities in the ReBUILD Consortium, partnering with Makerere University.

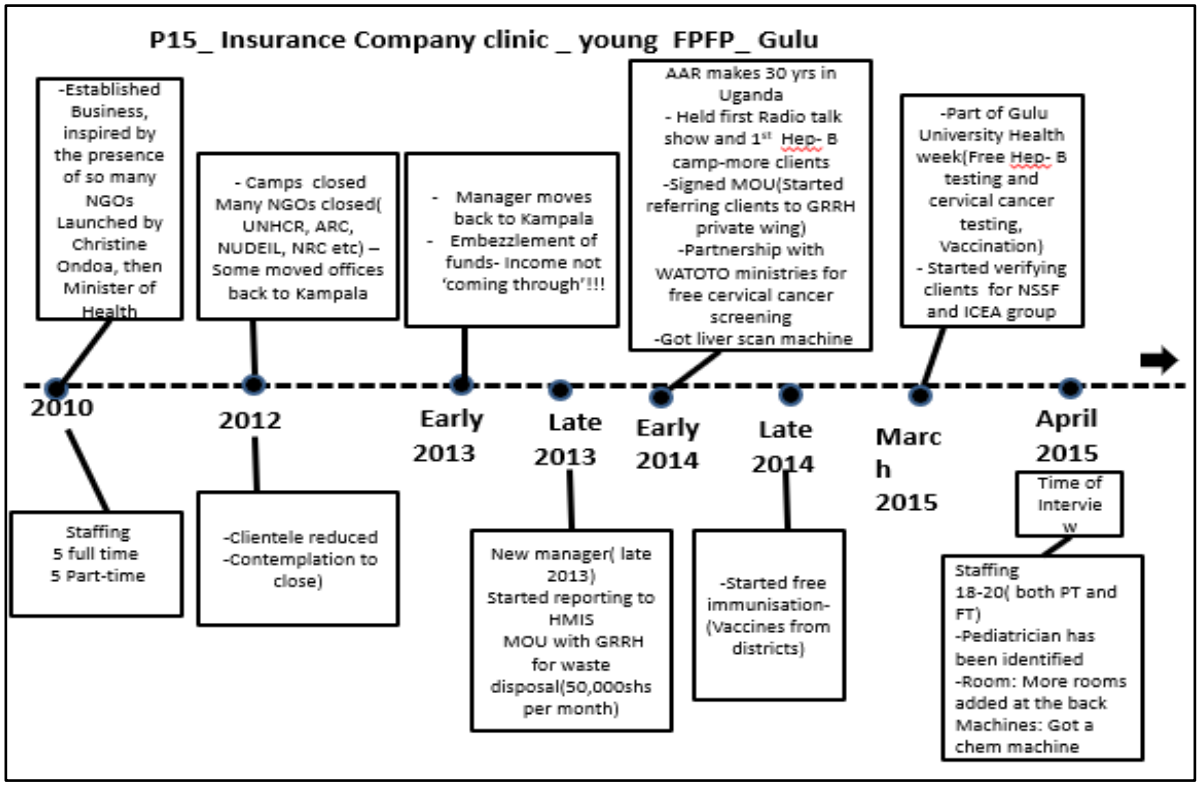
Ms. Namakula is undertaking research for her PHD: **" Health care Markets in post-conflict settings: Experiences of formal private for profit health care organisations in Gulu district, Northern Uganda(HDREC 279).** Her research seeks to understand the contribution of FPFPs to Health service delivery in Gulu during and after the conflict, their experiences and the challenges they face.

Between 23rd and 27th March 2015, Ms. Namakula conducted a mini survey of all formal (registered) Private for profit organisations (FPFP) in Gulu Municipality. During this visit, Ms. Namakula would like to follow up the survey with in-depth interviews and key informant interviews with other providers in the health care system as well as organisational life histories with FPFPs in Gulu. The people to be contacted include managers/owners/ in-charges of the FPFP facilities in Gulu, Health workers in FPFPs, Public Health facilities and private not for profit facilities, District health office, representatives of NGOs and membership bodies at district level and at the Ministry of Health. This research will be mainly conducted with in Gulu Municipality.

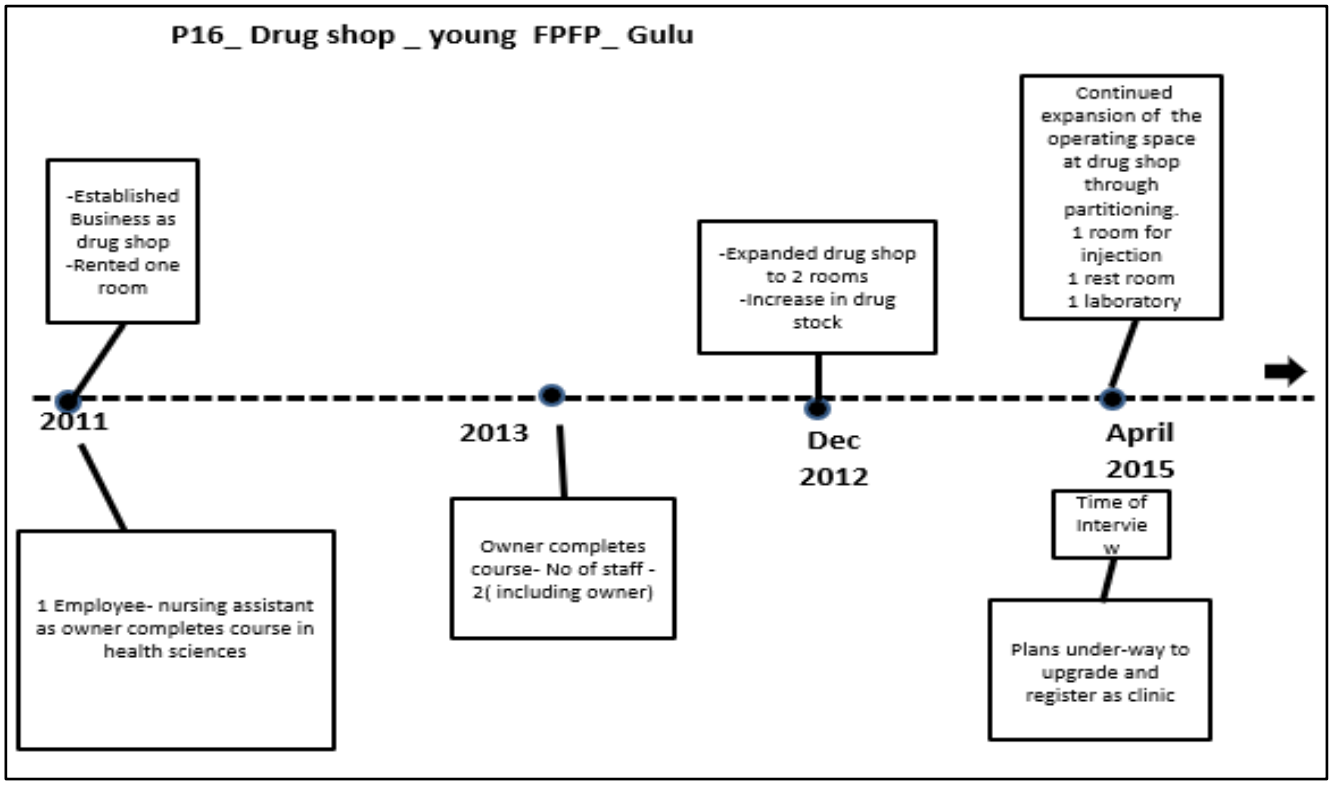
Ms. Namakula is working under supervision of Prof. Freddie Ssengooba, who is the chair, Department of Health Policy Planning and Management (HPPM) at Makerere University School of Public Health.
Any assistance extended to her to enable her conduct her research will be highly appreciated.
Thank You.
Yours Sincerely,

Dr. Freddie Ssengooba
Associate Professor and Chair, HPPM Department, School of Public Health
Also Namakula's Supervisor in Uganda

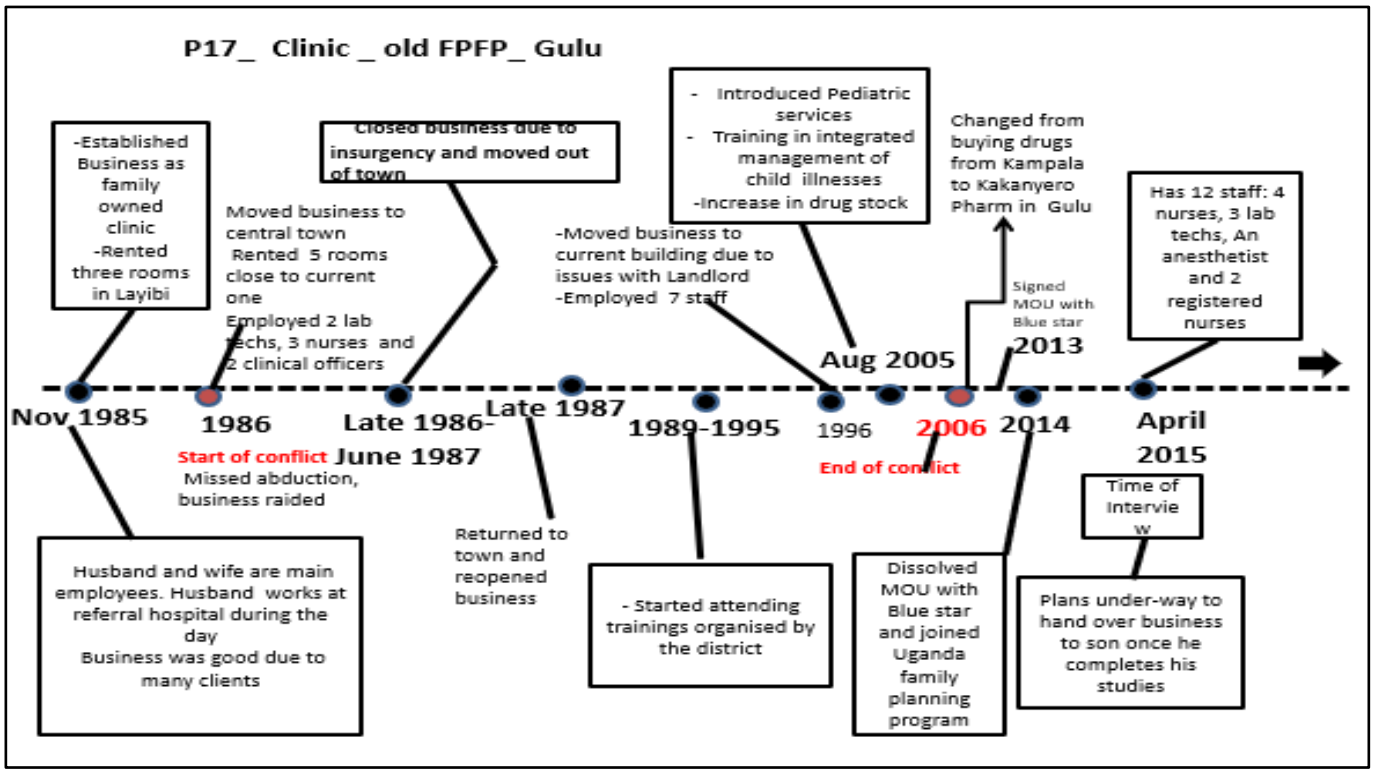
Appendix 12: Timeline for P15



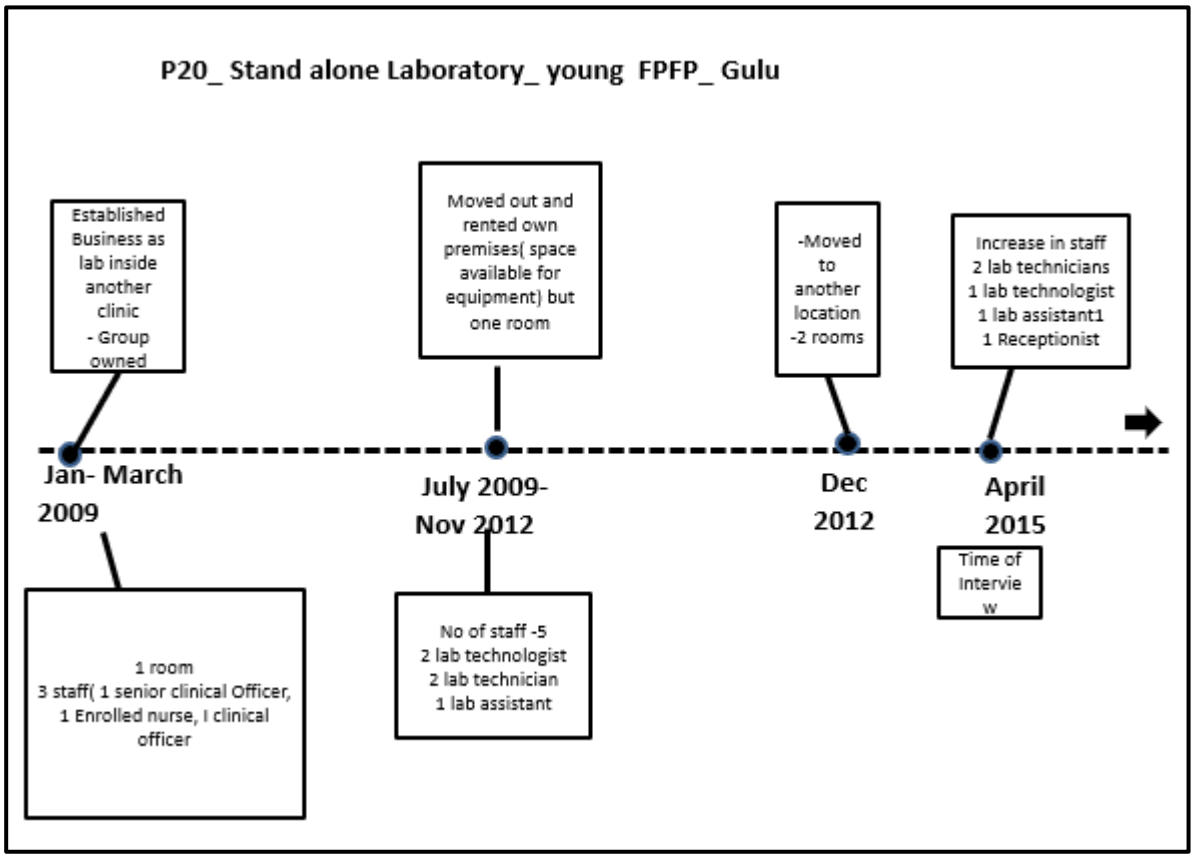
Appendix 13: Timeline for P16



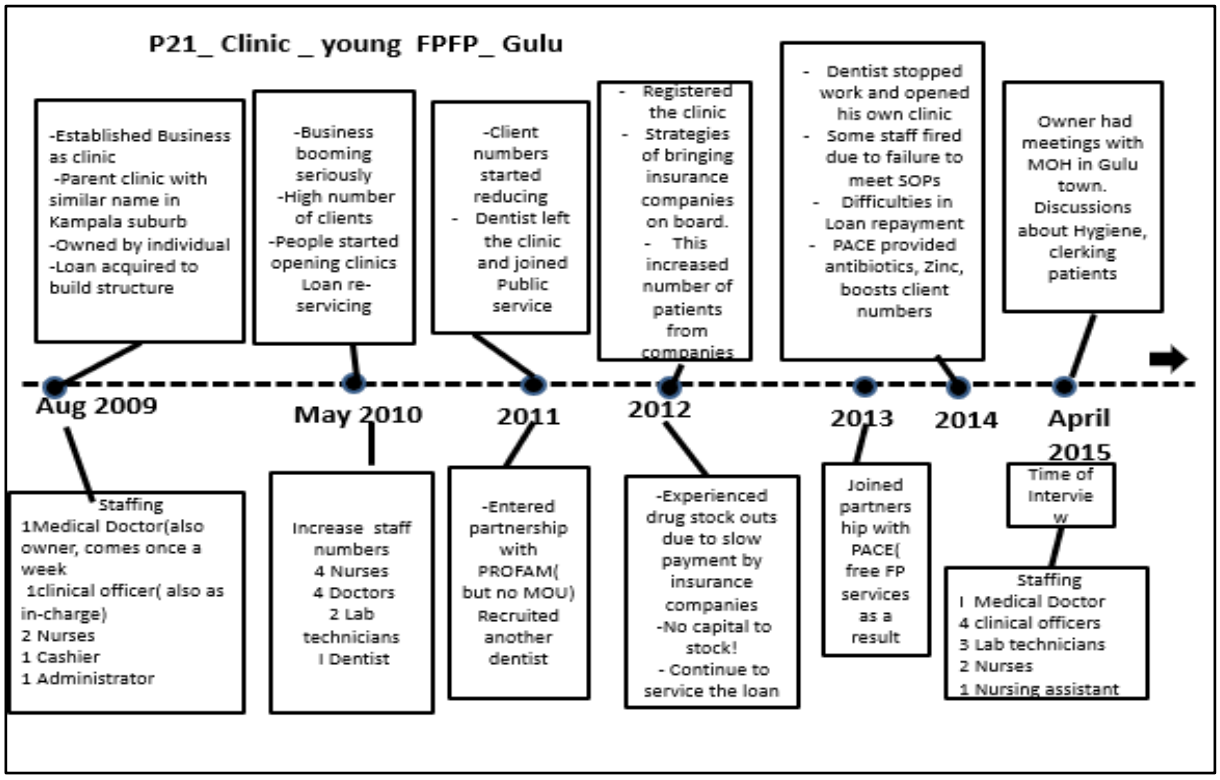
Appendix 14: Timeline for P17



Appendix 15: Timeline for P20



Appendix 16: Timeline for P21



Appendix 17: Timeline for P23